DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 05/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495362	A. BUILOING _____ B. WING _____	R-C 05/12/2016

NAME OF PROVIOER OR SUPPLIER	STREET AODRESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey ending 3/31/16 was conducted 5/10/16 through 5/12/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. One complaint was investigated during this survey. The census in this 190 certified bed facility was 183 at the time of the survey. The survey sample consisted of 28 current resident reviews (Residents #101 through #117, and #120 through #130) and two closed record reviews (Residents #118 through #119).	{F 000}	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157	1. Resident #114 responsible party (RP) is aware of orders for x-ray and pain medications. Resident #124 completed Vancomycin treatment on 5/18/16. Resident #124 is free from loose stools. Resident #115 was seen by MD on 5/12/16. Resident #116 no longer resides in the facility. RECEIVED JUN 09 2016 VDH/OLC	6/22/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte McCargo | TITLE: E.D. | [X6] DATE: 6-8-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to notify the physician and or RP (responsible party) of a change in a resident's condition for five of 30 residents in the survey sample, Resident #114, #124, #115, #116 and #130. 1. For Resident #114 facility staff failed to notify the resident's RP (responsible party) of new physician orders for a back x-ray and pain medication. 2. a. For Resident #124 facility staff failed to notify the resident's physician about the resident not receiving all prescribed doses of Vancomycin (an antibiotic) for the treatment of C-dif (clostridium difficile)*. 2. b. Facility staff failed to notify the resident's physician about the resident's continued loose stools in a resident with a diagnosis of clostridium difficile and had a roommate, Resident #125. 3. The facility staff failed to notify the physician and responsible party of a request to follow-up	F 157	2. Residents currently residing in the center have the potential to be affected. For residents currently residing in the center a review was done by the director of clinical services/designee to ensure that MD/RP was notified for changes in resident's condition and plan of care including order changes for the past thirty (30) days. 3. In-servicing has been provided to the licensed nurses and interdisciplinary team (IDT) by the director of clinical services/designee regarding notification to MD/RP regarding changes in condition and in plan of care including order changes. A random weekly review will be conducted by the director of clinical services/designee for five (5) residents per week for three (3) months to ensure that the MD/RP have been notified of change in care to include order changes. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 157	Continued From page 2 with a resident after a trip to the emergency room. 4. The facility staff failed to notify the physician and RP (responsible party) for Resident #116 following a threat made by Resident #130 toward Resident #116 on 5/9/16. 5. The facility staff failed to notify the physician and RP for Resident #130 following a threat made by Resident #130 toward Resident #116 on 5/9/16. The findings include: 1. Resident #114 was admitted to the facility on 4/26/16 with diagnoses that included but were not limited to: anxiety, dementia and bipolar disease*. The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 5/3/16 coded the resident with a four out of 15 on the BIMS (brief interview of mental status) indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring assistance of one staff member for dressing. Review of the physician's orders signed and dated 5/11/16 at 1:00 p.m. documented, "X-ray Thoraco-lumbar Spine (arrow pointing to right) Back Pain. Tramadol*** 25 mg po (by mouth) BID (twice a day) PRN (as needed) Pain." Review of the nurse's notes for 5/11/16 and 5/12/16 did not evidence documentation that the resident's RP had been notified of the new orders. An interview was conducted on 5/12/16 at 1:23 p.m. with RN (registered nurse) #1. When asked	F 157		

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F 157	Continued From page 3 what process staff followed when a resident had a new order, RN #1 stated, "We document it in the chart and notify the RP." An interview was conducted on 5/12/16 at 5:05 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what things staff notified the resident's RP about, ASM #2 stated that she would expect the RP to be notified with a change in the resident's condition. Review of the facility's policy titled, "Change in Resident Condition." documented in part, "Policy: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible. The Physician/Family/Responsible Part will be notified as soon as possible include (sic) but not limited to significant change, accident/incident, change in treatment... Procedure: Notification of the physician and agent/surrogate/contact person of a significant change in status shall routinely occur during the shift in which it occurs." On 5/12/16 at 3:20 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to	F 157		

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F 157	Continued From page 4 follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. *Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml **Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a695011.html 2. a. Resident #124 was admitted to the facility on 4/26/16 with diagnoses that included but were not limited to, end-stage kidney disease, high blood pressure, diabetes and chronic c-dif (clostridium difficile). The most recent MDS, an admission assessment, with an ARD (assessment reference date) of 5/3/16 coded the resident as 13 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. In section "I -- Active diagnoses" the resident was coded as having "ENTEROCOLITIS** DUE TO CLOSTRIDIUM DIFFICILE." Review of the physician's orders 4/26/16	F 157		

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F 157	Continued From page 5 documented, "VANCOMYCIN 250 MG (milligrams)/5 ML (milliliter) SOLUTION FOR > VANCOMYCIN ORAL 250 mg/5ML TAKE 10 ML (500 MG) BY MOUTH EVERY 6 HOURS FOR CDIFF..." Review of the MAR (medication administration record) for May 2016 documented, "VANCOMYCIN 250MG/5ML. TAKE 10ML (500) MG BY MOUTH EVERY 6 HOURS FOR CDIFF.." The medication was documented as not being given to the resident on seven out of 44 opportunities. On 5/7/16 it was documented, "12 (midnight) + 6A (6:00 a.m.) Vancomycin refused." Further review of the MAR did not evidence documentation on the other occasions the Vancomycin was not administered to the resident. Review of the May 2016 nurses' notes did not evidence documentation that the physician had been notified that the resident had not received the Vancomycin as ordered. An interview was conducted on 5/11/16 at 5:05 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked for the documentation for the physician notification of the Vancomycin not being given, ASM #2 stated, "I could not find any notification of the vanco (Vancomycin)." When asked if she expected staff to notify the physician of the missed doses of Vancomycin, ASM #2 stated, "Yes." An interview was conducted on 5/12/16 at 9:30 a.m. with OSM (other staff member) #8, the pharmacist. When asked the importance of taking antibiotics as ordered by the physician, OSM #8 stated, "If it's a contagious infection it would be important for the resident to take the medication as prescribed, it's like kids. After	F 157		

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they're been on antibiotics and not contagious they can go back to school, the elderly would be the same."

An interview was conducted on 5/12/16 at 9:35 a.m. with ASM #6, the medical director. When asked when if a resident did not receive prescribed medications, ASM #6 stated, "After two missed doses the doctor and the family need to be called." When asked why it was important for residents to receive the antibiotics as ordered, ASM #6 stated, "The patient needs to be cleared of infection, it can worsen or spread (if not treated)."

An interview was conducted on 5/12/16 at 11:40 a.m. with LPN (licensed practical nurse) #1. When asked the process staff followed if a resident missed doses of their medications, LPN #1 stated, "If not able to get or give the medication as ordered I notify the MD (medical doctor), see if he wants something else to be given in its place."

Review of the facility's policy titled, "Change in Resident Condition." documented in part, "Policy: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible. The Physician/Family/Responsible Part will be notified as soon as possible include (sic) but not limited to significant change, accident/incident, change in treatment... Procedure: Notification of the physician and agent/surrogate/contact person of a significant change in status shall routinely occur during the shift in which it occurs."

On 5/12/16 at 3:20 p.m. ASM #1, the

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F 157	Continued From page 7 administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. *The stool C. difficile toxin test detects harmful substances produced by the bacterium Clostridium difficile (C. difficile). This infection is a common cause of diarrhea after antibiotic use. https://www.nlm.nih.gov/medlineplus/ency/article/003590.htm **Enterocolitis -- According to the medical literature, signs and symptoms of mastocytic enterocolitis primarily include chronic, intractable diarrhea and abdominal pain. Other symptoms that have occasionally been reported include constipation, nausea, and/or vomiting. https://rarediseases.info.nih.gov/gard/10176/mastocytic-enterocolitis/resources/9 2. b. Resident #124 was admitted to the facility on 4/26/16 with diagnoses that included but were not limited to, end-stage kidney disease, high blood pressure, diabetes and chronic c-dif (clostridium difficile).	F 157		

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F 157	Continued From page 10 Review of Resident #124's MAR dated 5/5/15 documented, "Anusol Supp 1 via rectum QHS X 10 day (sic)." It was documented that the resident received the suppository on 5/6/16, 5/7/16, 5/8/16, 5/10/16 and 5/11/16. Further review documented, "Tucks to rectal area after each loose stool as needed PRN." There was no documentation that the resident had been treated with the Tucks. Review of the physician's orders on 5/6/16 documented, "C diff stool X 1." Review of the unit's 24 hour report documented in part: 5/6/16, "(Name of resident #124). ABT (antibiotic)/C-diff. ?Contact Precautions? 11-7 No reactions X1 loose stool. Vanc (Vancomycin) in route this am from pharmacy. 7-3. ABT; no adverse reactions. Loose stool X 1. 3-11 (3:00 p.m. to 11:00 p.m.) stool samp (sample). Call lab for pickup." 5/8/16, "(Name of resident #124). 11-7 Loose Stools." 5/9/16, "(Name of resident #124). 11-7. Resident is not on contact precautions, 1 reported loose stool....she has loose stools daily. Please F/U (follow up) in am (c with a line over it meaning with) order for contact, she ambulates with loose foul stool." 5/10/16, "(Name of resident #124)., 11-7. D/T (due to) No F/U on stool sample called Lab (laboratory) No record received. Loose stools daily (with) foul odor. "?contact precaution?" Resides in semi-private room with loose/foul stool. *Tx (treated) for C-diff. F/U (with) MD (medical doctor) RE: contact precaution order." 5/11/16, "(Name of resident #124). F/U (with) MD RE: CONTACT PRECAUTION."	F 157		

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F 157	Continued From page 11 Review of the resident's record did not evidence documentation that the physician had been notified about the loose stools or to follow up on the need for contact precautions. Review of Resident #124's nurses' notes dated 5/10/16 and timed 7:00 a.m. to 3:00 p.m. documented in part, "Incontinent of bowel and bladder." 3:00 p.m. to 11:00 p.m. nurse's note documented in part, "Rsd (resident) has diagnosis of c-diff (a 0 with a line through it meaning no) contact precautions present/ in semi private room (with) roommate." The documentation did not evidence that the physician had been notified. An interview was conducted on 5/12/16 with ASM #6, the medical director. When asked what if anything would he do if a resident with a diagnosis of c-diff continued to have loose stools, ASM #6 stated, "If they're still having loose stools they should call the doctor. I would keep the resident in isolation if still having loose stools because the c-diff is still positive." An interview was conducted with CNA (certified nursing assistance) #11, the aide caring for Resident #124. When asked what process staff followed if a resident had loose stools CNA #11 stated, "Notify the nurse." When asked if the resident had had any loose stools that day, CNA #11 stated, "She hasn't had any." An interview was conducted with ASM #3, the assistant director of nursing. When asked about the 24 hour report for Resident #124, ASM #3 stated, "If I speak honestly, I don't recall being part of that discussion." When asked if she would be concerned about the resident continuing to	F 157		

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F 157	Continued From page 12 have loose stools, ASM #2 stated, "Absolutely, we would call the doctor and get a (stool) specimen." On 5/12/16 at 3:20 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Change in Resident Condition." documented in part, "Policy: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible. The Physician/Family/Responsible Part will be notified as soon as possible include (sic) but not limited to significant change, accident/incident, change in treatment... Procedure: Notification of the physician and agent/surrogate/contact person of a significant change in status shall routinely occur during the shift in which it occurs." Review of the facility's policy dated 11/30/2014 titled, "Comprehensive 24 Hour Report (Quality Assurance)" documented in part, "Policy: Clinical Services shall have a written method for monitoring and communicating clinical information, unusual occurrence information, and administrative matters on a twenty-four (24) hour basis. Procedure: Examples of additional issues which may be addressed on the report are as follows but should not be considered all inclusive: Residents whose condition requires extra attention and supervision...Physician visits and concerns or issues." No further information was provided prior to exit. Basic Nursing, Essential for Practice, 6th edition	F 157		

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F 157	Continued From page 13 (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. 3. The facility staff failed to notify the physician and responsible party of a request to follow-up with a resident after a trip to the emergency room. Resident #115 was admitted to the facility on 4/26/11 with diagnoses that included, but were not limited to: cancer, cirrhosis, hepatitis C, diabetes, hypertension, and gastroesophageal reflux disease. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 2/8/16. Resident # 115 was coded as scoring 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was cognitively intact. On 5/4/16 Resident # 115 was sent to the emergency room of a local hospital because of a complaint of chest pains. A review of Resident #115's clinical record revealed a nurse's note dated 5/5/16 at 2:20 a.m. that documented, "Resident returned from (name of local hospital). No new orders at this time. Follow up with MD (medical doctor) within two days." Review of the hospital record revealed the following documentation dated 5/5/16, "Follow-up	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	R-C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 157	Continued From page 8 The most recent MDS, an admission assessment, with an ARD of 5/3/16 coded the resident as 13 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as being frequently incontinent of stool. In section "I -- Active diagnoses" the resident was coded as having "ENTEROCOLITIS** DUE TO CLOSTRIDIUM DIFFICILE." Resident #125 was admitted to the facility on 2/21/11 with diagnoses that included but were not limited to: arthritis, high blood pressure and muscle weakness. Resident #125's most recent MDS, annual assessment, with an ARD of 3/8/16 coded the resident as having 15 out of 15 on the BIMS, indicating that the resident was cognitively intact to make daily decisions. The resident was coded as needing staff assistance for activities of daily living except for eating which the resident could do after the tray was prepared. The resident was coded as always being incontinent of urine and stool. Review of the resident's clinical record did not evidence that the resident had loose stools. An observation was made of Residents #124 and #125 on 5/11/16 at 1:42 p.m. Resident #124 was sitting up in a wheelchair next to her bed. Resident #125 was sitting up in a wheelchair placed at the foot of her bed. An observation was made of Residents #124 and #125 on 5/12/16 at 9:07 a.m. Resident #124 was	F 157		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495362	A. BUILOING _____ B. WING _____	R-C 05/12/2016

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 157	Continued From page 9 lying in bed on her left side, she was wearing a brief that was not visibly soiled. Resident #125 was sitting up in a wheelchair placed at the foot of her bed. Review of Resident #124's care plan dated 4/26/16 documented in part, "6. Infection Alert. Type: Chronic CDiff. Monitor for S/S (signs and symptoms) infection -- loose stools. Meds as ordered. Isolation: D/C (discontinued)." Review of the physician's orders dated, 4/28/16 documented, "D/C (discontinue) contact precautions." Review of Resident #124's nurses' notes dated 5/5/16 documented in part, "Incontinent of bowel and bladder. N.O. (new order) from MD anusol supp (suppository) 1 via rectum daily X (times) 10 days, tucks to rectal area after each loose stool PRN (as needed) for hemorrhoids." Review of the physician's orders on 5/5/16 documented, "Anusol Supp 1 via rectum daily X 10 days Tucks to rectal area after each loose stool." Review of Resident #124's nurses' notes dated 5/6/16 and timed "11-7 (11:00 p.m. to 7:00 a.m.)Resident remain (sic) skilled care, ABT (antibiotic)/c-diff continues...X1 loose stool." The documentation did not evidence that the physician had been notified. Review of the nurses' notes dated 5/6/16 and timed "7-3 (7:00 a.m. to 3:00 p.m.)" documented, "Resident had loose stools X1 this shift. No blood noted when rendering incontinence care." The documentation did not evidence that the physician had been notified of the loose stool.	F 157		

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F 157	Continued From page 14 Information: Follow up with (name of Resident # 115's physician) Call in 2 days." Further review of the clinical record revealed documentation of the most recent physician progress was dated 4/1/16. During an interview on 5/11/16 at 3:10 p.m. with OSM (other staff member) # 1, medical records staff, confirmed that this was the most recent physician progress note. Further review of the clinical record revealed no documentation that the physician or responsible party had been notified of the recommendation to "follow-up in 2 days". During an interview on 5/11/16 at 3:25 p.m. with LPN (Licensed practical nurse) # 3, Resident # 115's hospital record was reviewed. LPN # 3 stated that one should put the information on the 24 hour report, put a note in the doctor's book so that the doctor would know to follow-up with the resident in 2 days, let the RP (responsible party) know that the doctor will be following up with the resident in 2 days. During an interview on 5/11/16 at 3:40 p.m. with LPN # 1, LPN # 1 stated that one would put the information to follow-up with the physician on the 24 hour report and one would also put a note in the doctor's book. LPN # 1 was asked to check the 24 hour report and the doctor's book for a note. LPN stated that there was a note on the 24 hour report but no note in the doctor's book. Review of the 24 hour report revealed the following documentation: next to Resident # 115's name: Under "Clinical Status Change" "Please notify MD of hyponatremia*" Under 11-7 "(name of local hospital) for chest pain returned at 2:20 a.m." Under 7-3 "No complaints voiced about pain or discomfort" Under 3-11 "(symbol for no)	F 157		

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F 157	Continued From page 15	F 157		

pain/distress" Under "Reminders were boxes next to 'Dr' (doctor) & 'Family'" "Time Notified:" (with a place to write the time) neither of the boxes was checked.

During an interview on 5/11/16 at 3:50 p.m. LPN # 1 offered to call the physician to see if he was aware of the recommendation to follow-up in 2 days. LPN # 1 reported that the physician did not see the Resident and did not know there was a recommendation for a follow-up. LPN # 1 further stated that the physician asked that (name of the medical director) see the Resident.

During an interview on 5/11/16 at 4:02 p.m. LPN # 1 stated that she had made a notation in the doctor's book for the medical director to see the Resident.

During an interview on 5/12/16 at 9:50 a.m. with ASM (administrative staff member) # 1, the administrator, this concern was shared and the facility policies on notification and 24 hour report were requested.

Review of the facility policy: "Change in Resident Condition: Under "Policy: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible." Under "Procedure: The primary Clinical Nurse will communicate to the nurse manager/supervisor any change in resident condition as it occurs. This will also be communicated in the 24 hours report as well. The Physician/Family/Responsible Party will be notified as soon as possible include but not limited to significant change, accident/incident, change in treatment, transfer/D/C (discharge)..."

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F 157	Continued From page 16 Review of the facility policy: "Comprehensive 24 Hour Report" Under "Policy: Clinical Services shall have a written method for monitoring and communicating clinical information, unusual occurrence information, and administrative matters on a twenty-four (24) hours basis." Under "Procedure: The Clinical Nurse shall complete the 24-hour report form for his/her designated unit and shift. Updates to the census information such as admissions, discharges, LOAs (leave of absence), transfers and deaths shall be documented for each unit and each shift..." During an interview on 5/12/16 at 10:20 a.m. with ASM # 3, the assistant director of nurses, ASM # 3 reported that the medical director had seen the Resident (Resident # 115). At this time a request was made for any note the medical director had written. Prior to exit no further information was provided. In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. "Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient." *Hyponatremia is a condition that occurs when the level of sodium in your blood is abnormally low.	F 157		

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F 157	Continued From page 17 <https://www.nlm.nih.gov/medlineplus/ency/article/000394.htm> 4. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is	F 157		

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F 157	Continued From page 18 upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of the Admission Care Plan for Resident #116 dated 5/2/16 listed the following interventions under the heading "Falls/Safety/Elopement Risks:" Orthostatic hypotension precautions (to prevent low blood pressure when quickly sitting or standing up), ambulation devices as necessary, assess cognitive status as ability to ask for assistance, assess resident footwear for fit and non-skid soles, encourage activity, safety checks, orthostatic BP (blood pressure) checks. Further review of the clinical record revealed no further evidence that the facility staff notified Resident #116's physician or RP of the threat made by Resident #130. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #3, the assistant director of nursing, was interviewed regarding the above referenced nurse's note. She was asked to provide the surveyor with an incident report and investigation, or any other evidence that of physician and RP notification of the threat Resident #130 made to Resident #116. She stated that she did not have any further documentation regarding this incident. She stated that she was aware that the nurse working the floor when the incident occurred separated the residents immediately, and kept Resident #116 at the nurse's station until Resident #130 had gone to sleep. She stated that when Resident #130 went to sleep, the facility staff assisted Resident #116 back into his bed (in the	F 157		

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F 157	Continued From page 19 same room as Resident #130). On 5/11/16 at 6:10 p.m., LPN #11 was interviewed about the above referenced incident. She stated that she was initially focused on Resident #116's fall and on assessing him for any injuries. She stated that her assessment revealed no apparent injuries for Resident #116. She stated that Resident #116 was being "very loud and unsteady" in his room, and that Resident #130 said: "If you can't make him sit his [expletive] down, I will make him sit it down." She stated that she put Resident #116 in a wheelchair and took him to sit at the nurse's station for the duration of the shift. She stated that Resident #130 went to sleep, and she assisted Resident #116 back to his bed at that time. She stated that she told the supervisor about this, and that the supervisor told her to make sure the residents were separated and monitored to make sure there were no other incidents. When asked if she notified the physician or RP of the threat, she stated: "No, I didn't. I know I should have. I was more focused on the fall. I told them about the fall, but I didn't tell them about the rest." On 5/12/16 at 8:25, LPN #9, the unit manager, was interviewed regarding what she would do if she was notified of a resident threatening another resident. She stated that the residents should be separated for safety. She stated that she would alert the director of nursing. She stated that the doctor and the RP should also be notified. On 5/12/16 at 8:40 a.m., LPN #10, the evening supervisor on 5/9/16, was interviewed regarding the process to be followed when a resident was threatened by a roommate. She stated: "If it was an actual threat, I would separate them and notify my boss. I would get witness statements from	F 157		

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F 157	Continued From page 20 anyone who saw or heard anything, whether it was staff or residents." When asked how she determined that a threat was an "actual" one, she stated: "An actual threat would be if a patient said that they would hurt someone or had actually hurt someone." When asked about the above referenced incident between Resident #116 and Resident #130, she stated: "It was not brought to me as a threat." She said that another staff member had told her that Resident #130 had made a statement and that we needed to do something about Resident #116 falling all over the place." She stated that her concern was much more about the resident's unsteadiness and risk for falls. When asked if the physician and RP should have been notified, she stated that both should have been notified. On 5/11/16 at 5:50 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns. A review of the facility policy entitled "Resident Incident/Accident Reports" revealed, in part, the following: "Any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report...Following nursing assessment, the physician will be notified of any noted or suspected injury, and will implement appropriate interventions. The event, along with assessment, physician and other required notification will be documented in the clinical record. Resident's family or legal representative will be notified of incident." No further information was provided prior to exit.	F 157		

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F 157	Continued From page 21 5. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood	F 157		

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F 157	Continued From page 22 pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of Resident #130's clinical record revealed no nurses' notes after 5/2/16. The record contained no evidence that Resident #130's physician or RP were notified of the incident between Resident #130 and Resident #116 on 5/9/16. On 5/12/16 at 1:10 p.m., LPN #8 was interviewed regarding what should be done if a resident makes a threat against another resident. She stated: "It should go in both resident charts. I would write a note in each of the charts. I would say what happened and who I called." When asked whom she would notify, she stated: "The doctor and the family." On 5/12/16 at 1:15 p.m., LPN #9, a unit manager, was interviewed regarding what should be documented if a resident makes a threat against another resident. She stated that the events should be documented in both residents' progress notes. She stated that after the residents are separated and the physician and RP are notified, everything that happened with both residents should be documented. On 5/12/16 at 3:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, and ASM #5, the corporate MDS consultant, were informed of these concerns. No further information was provided prior to exit. COMPLAINT DEFICIENCY	F 157		
(F 225}	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	(F 225}		

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
{F 225} SS=D	Continued From page 23 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by:	{F 225}	1. Resident #116 no longer resides in the facility. Resident #130 resides in a private room. 2. Residents currently residing in the center have the potential to be affected. A review has been conducted by the administrator/designee of facility reported incidents within the last thirty (30) days to ensure that policies were implemented regarding allegations of abuse. 3. In-servicing has been provided to current employees by the administrator/designee regarding implementation of polices for abuse; including investigating abuse. A random weekly review for facility reportable incidents will be conducted by the administrator/designee weekly for three (3) months to ensure that policies have been implemented including investigations for facility reportable incidents has been conducted as required for allegation of abuse.	6/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	R-C 05/12/2016

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{F 225}	Continued From page 24 Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to investigate an allegation of resident to resident abuse, and to protect a resident from further abuse for one of 30 residents in the survey sample, Resident #116. The facility staff failed to thoroughly investigate an incident in which Resident #130 threatened to harm Resident #116. The facility staff failed to permanently separate the residents after this threat occurred. The findings include: Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look	{F 225}	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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{F 225}	Continued From page 25 back period. On the following dates and times during the survey, Residents #116 and #130 were observed in the same room: 5/10/16 at 3:15 p.m.; 5/11/16 at 7:40 a.m. and 5:15 p.m. On 5/12/16 at 8:10 a.m., Resident #116 was observed to have been moved to a different room. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of the Admission Care Plan for Resident #116 dated 5/2/16 listed the following interventions under the heading "Falls/Safety/Elopement Risks:" Orthostatic hypotension precautions (to prevent low blood pressure when quickly sitting or standing up), ambulation devices as necessary, assess cognitive status as ability to ask for assistance, assess resident footwear for fit and non-skid soles, encourage activity, safety checks, orthostatic BP (blood pressure) checks. Further review of the clinical record revealed no further evidence that the facility staff addressed	{F 225}		

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{F 225}	Continued From page 26 Resident #130's threats to Resident #116, or assessed Resident #116 for safety needs. The record revealed no evidence that Resident #116 was protected from further threats or harm from Resident #130. On 5/11/16 at 3:55 p.m., LPN (licensed practical nurse) #2 was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated: "That could be considered abuse." She stated that the residents are separated, and that the staff should try to determine the cause of the conflict. She stated that one of the residents should be assigned to another room in the facility. She stated that the social worker would be informed of the incident at the next day's morning meeting of the interdisciplinary team. On 5/11/16 at 4:00 p.m., OSM (other staff member) #7, the social worker, was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated that the residents should be immediately separated, and the safety of the resident who has been threatened should be ensured. She stated if the incident happens during a weekday, she would be notified immediately by the floor staff. She stated if the incident happened after hours, she would be told at the next morning meeting. She stated once she was informed of the incident, she would immediately go to interview both residents, and make sure that a permanent room change had already been made. She said she would attempt to facilitate that room change if the incident occurred during office hours on a week day. When shown the above referenced nurse's note regarding the threat made by Resident #130 to Resident #116, she stated: "I was not aware of that. I will go ahead and make	{F 225}		

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{F 225}	Continued From page 27 sure they are separated." On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #3, the assistant director of nursing, was interviewed regarding the above referenced nurse's note. She was asked to provide the surveyor with an incident report and investigation regarding the threat Resident #130 made to Resident #116. She stated she did not have any further documentation regarding this incident. She stated she was aware that the nurse working the floor when the incident occurred separated the residents immediately, and kept Resident #116 at the nurse's station until Resident #130 had gone to sleep. She stated when Resident #130 went to sleep; the facility staff assisted Resident #116 back into his bed (in the same room as Resident #130). On 5/11/16 at 6:10 p.m., LPN #11 was interviewed about the above referenced incident. She stated she was initially focused on Resident #116's fall and on assessing him for any injuries. She stated her assessment revealed no apparent injuries for Resident #116. She stated Resident #116 was being "very loud and unsteady" in his room, and Resident #130 said: "If you can't make him sit his [expletive] down, I will make him sit it down." She stated she put Resident #116 in a wheelchair and took him to sit at the nurse's station for the duration of the shift. She stated Resident #130 went to sleep, and she assisted Resident #116 back to his bed at that time. She stated she told the supervisor about this, and the supervisor told her to make sure the residents were separated and monitored to make sure there were no other incidents. When asked if she recorded any of this information in the clinical record, she stated: "No, I didn't. I know I should have." When asked if she took any action to	{F 225}		

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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{F 225}	Continued From page 28 notify the social worker, she stated: "No, I did not." She stated she notified the unit manager of what happened when she returned to work the next morning. On 5/12/16 at 8:25, LPN #9, the unit manager, was interviewed regarding what she would do if she was notified of a resident threatening another resident. She stated the residents should be separated for safety. She stated she would alert the director of nursing. When asked if she would document any of her actions, she stated that she would write a nurse's note about what happened and about any action she took. She stated the doctor and the RP (responsible party) should also be notified. When asked if she was told about an incident between Resident #116 and #130, she stated: "I didn't hear exactly what was said. I was just told they were arguing. I told the nurse that we need to get them moved." When asked if this information was shared in the morning meeting at any point, she stated: "I brought the chart to the morning meeting on [the day following the incident] (5/10/16)." She stated: "There absolutely should have been an investigation." She stated she could not recall exactly what she had shared or what had been discussed at the morning meeting on 5/10/16. On 5/12/16 at 8:40 a.m., LPN #10, the evening supervisor on 5/9/16, was interviewed regarding the process to be followed when a resident was threatened by a roommate. She stated: "If it was an actual threat, I would separate them and notify my boss. I would get witness statements from anyone who saw or heard anything, whether it was staff or residents." When asked how she determined that a threat was an "actual" one, she stated: "An actual threat would be if a patient said that they would hurt someone or had actually	{F 225}		

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{F 225}	Continued From page 29 hurt someone." When asked about the above referenced incident between Resident #116 and Resident #130, she stated: "It was not brought to me as a threat." She said that another staff member had told her Resident #130 had made a statement and that we needed to do something about Resident #116 falling all over the place." She stated her concern was much more about the resident's unsteadiness and risk for falls. She stated a CNA {certified nursing assistant) sat with Resident #116 the remainder of the night shift to make sure he was safe. She stated: "We kept him safe all night. We monitored him all night." She stated if she had been told exactly what Resident #130 had said, she would have moved Resident #116 to a different room. When asked if she passed on any information about this incident to the next shift, she stated: "I would have passed it on myself. It was not on the 24-hour report. I should have put it on there." When asked if the incident should have been investigated as an incident of abuse, she stated: "Yes. Yes it should have. If I had known what really happened, I would have." On 5/11/16 at 5:50 p.m., ASM #1, ASM #2, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns. Policies regarding resident safety/protection from abuse were requested. A review of the facility policy entitled "Resident Abuse" revealed, in part, the following: "An abusive act is any act or omission, which may cause or causes actual physical, psychological or emotional harm or injury to a resident...Any action that may cause or causes actual physical, psychological or emotional harm, which is not caused by simple negligence, constitutes abuse...Furthermore, the Administration of The	{F 225}		

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{F 225}	Continued From page 30 Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers...All reported events {bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services...Any employee who witnesses or who has knowledge of an act of abuse or an allegation of abuse to a resident is obligated to report such information immediately to their supervisor." No further information was provided prior to exit.	{F 225}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement a policy to investigate an allegation of resident to resident abuse, and to protect a resident from further abuse for one of 30 residents in the survey sample, Resident #116. The facility staff failed to thoroughly investigate an incident in which Resident #130 threatened to harm Resident #116. The facility staff failed to permanently separate the residents after this threat occurred. The findings include: Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to:	{F 226}	1. Resident # 116 no longer resides in the facility. 2. Residents currently residing in the center have the potential to be affected. A review has been conducted by the administrator/designee of facility reported incidents within the last thirty (30) days to ensure that an investigation was conducted. 3. In-servicing has been provided to current employees by the administrator/designee regarding investigating allegations of abuse. A random weekly review for facility reportable incidents will be conducted by the administrator/designee weekly for three (3) months to ensure that investigation has been conducted as required for allegation of abuse.	6/22/16

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(F 226)	Continued From page 31 schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. On the following dates and times during the survey, Residents #116 and #130 were observed in the same room: 5/10/16 at 3:15 p.m.; 5/11/16 at 7:40 a.m. and 5:15 p.m. On 5/12/16 at 8:10 a.m., Resident #116 was observed to have been moved to a different room. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number} by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents} state they didn't see him fall but they heard him hit the floor. Resident	(F 226)	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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{F 226}	Continued From page 32 extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p {blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of the Admission Care Plan for Resident #116 dated 5/2/16 listed the following interventions under the heading "Falls/Safety/Elopement Risks:" Orthostatic hypotension precautions (to prevent low blood pressure when quickly sitting or standing up), ambulation devices as necessary, assess cognitive status as ability to ask for assistance, assess resident footwear for fit and non-skid soles, encourage activity, safety checks, orthostatic BP (blood pressure) checks. Further review of the clinical record revealed no further evidence that the facility staff addressed Resident #130's threats to Resident #116, or assessed Resident #116 for safety needs. The record revealed no evidence that Resident #116 was protected from further threats or harm from Resident #130. On 5/11/16 at 3:55 p.m., LPN (licensed practical nurse) #2 was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated: "That could be considered abuse." She stated that the residents are separated, and that the staff should try to determine the cause of the conflict. She stated that one of the residents should be assigned to another room in the facility. She stated that the social worker would be informed of the incident at the next day's morning meeting of the interdisciplinary team.	{F 226}		

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{F 226}	Continued From page 33 On 5/11/16 at 4:00 p.m., OSM (other staff member) #7, the social worker, was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated that the residents should be immediately separated, and that the safety of the resident who has been threatened should be ensured. She stated that if the incident happens during a weekday, she would be notified immediately by the floor staff. She stated that if the incident happened after hours, she would be told at the next morning meeting. She stated that once she was informed of the incident, she would immediately go to interview both residents, and make sure that a permanent room change had already been made. She said that she would attempt to facilitate that room change if the incident occurred during office hours on a week day. When shown the above referenced nurse's note regarding the threat made by Resident #130 to Resident #116, she stated: "I was not aware of that. I will go ahead and make sure they are separated." On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #3, the assistant director of nursing, was interviewed regarding the above referenced nurse's note. She was asked to provide the surveyor with an incident report and investigation regarding the threat Resident #130 made to Resident #116. She stated that she did not have any further documentation regarding this incident. She stated that she was aware that the nurse working the floor when the incident occurred separated the residents immediately, and kept Resident #116 at the nurse's station until Resident #130 had gone to sleep. She stated that when Resident #130 went to sleep, the facility staff assisted Resident #116 back into his	{F 226}		

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{F 226}	Continued From page 34 bed (in the same room as Resident #130). On 5/11/16 at 6:10 p.m., LPN #11 was interviewed about the above referenced incident. She stated that she was initially focused on Resident #116's fall and on assessing him for any injuries. She stated that her assessment revealed no apparent injuries for Resident #116. She stated that Resident #116 was being "very loud and unsteady" in his room, and that Resident #130 said: "If you can't make him sit his [expletive] down, I will make him sit it down." She stated that she put Resident #116 in a wheelchair and took him to sit at the nurse's station for the duration of the shift. She stated that Resident #130 went to sleep, and she assisted Resident #116 back to his bed at that time. She stated that she told the supervisor about this, and that the supervisor told her to make sure the residents were separated and monitored to make sure there were no other incidents. When asked if she recorded any of this information in the clinical record, she stated: "No, I didn't. I know I should have." When asked if she took any action to notify the social worker, she stated: "No, I did not." She stated that she notified the unit manager of what happened when she returned to work the next morning. On 5/12/16 at 8:25, LPN #9, the unit manager, was interviewed regarding what she would do if she was notified of a resident threatening another resident. She stated that the residents should be separated for safety. She stated that she would alert the director of nursing. When asked if she would document any of her actions, she stated that she would write a nurse's note about what happened and about any action she took. She stated that the doctor and the RP should also be notified. When asked if she was told about an	{F 226}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 35 incident between Resident #116 and #130, she stated: "I didn't hear exactly what was said. I was just told they were arguing. I told the nurse that we need to get them moved." When asked if this information was shared in the morning meeting at any point, she stated: "I brought the chart to the morning meeting on [the day following the incident] (5/10/16)." She stated: "There absolutely should have been an investigation." She stated she could not recall exactly what she had shared or what had been discussed at the morning meeting on 5/10/16. On 5/12/16 at 8:40 a.m., LPN #10, the evening supervisor on 5/9/16, was interviewed regarding the process to be followed when a resident was threatened by a roommate. She stated: "If it was an actual threat, I would separate them and notify my boss. I would get witness statements from anyone who saw or heard anything, whether it was staff or residents." When asked how she determined that a threat was an "actual" one, she stated: "An actual threat would be if a patient said that they would hurt someone or had actually hurt someone." When asked about the above referenced incident between Resident #116 and Resident #130, she stated: "It was not brought to me as a threat." She said that another staff member had told her that Resident #130 had made a statement and that we needed to do something about Resident #116 falling all over the place." She stated that her concern was much more about the resident's unsteadiness and risk for falls. She stated that a CNA (certified nursing assistant) sat with Resident #116 the remainder of the night shift to make sure he was safe. She stated: "We kept him safe all night. We monitored him all night." She stated that if she had been told exactly what Resident #130 had said, she would have moved Resident #116 to a	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	R-C 05/12/2016

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 226}	Continued From page 36 different room. When asked if she passed on any information about this incident to the next shift, she stated: "I would have passed it on myself. It was not on the 24-hour report. I should have put it on there." When asked if the incident should have been investigated as an incident of abuse, she stated: "Yes. Yes it should have. If I had known what really happened, I would have." On 5/11/16 at 5:50 p.m., ASM #1, ASM #2, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns. Policies regarding resident safety/protection from abuse were requested. "A review of the facility policy entitled "Resident Abuse" revealed, in part, the following: "An abusive act is any act or omission, which may cause or causes actual physical, psychological or emotional harm or injury to a resident...Any action that may cause or causes actual physical, psychological or emotional harm, which is not caused by simple negligence, constitutes abuse...Furthermore, the Administration of The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers...All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services...Any employee who witnesses or who has knowledge of an act of abuse or an allegation of abuse to a resident is obligated to report such information immediately to their supervisor...Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation of the allegation. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed	{F 226}		

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{F 226}	Continued From page 37 as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the Abuse Coordinator No further information was provided prior to exit.	{F 226}		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined that facility staff failed to promote dignity for one of 30 residents in the survey sample; Resident #120. Facility staff failed to promote dignity by allowing Resident #120 to dress in pants that were labeled with a resident's name on the outside, visible to the public. The findings include: Resident #120 was admitted to the facility on 3/31/2008 with diagnoses that included but were not limited to hypothyroidism, Alzheimer's disease, high blood pressure, dementia with behavioral disturbance, and anxiety disorder. Resident #120's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (assessment reference date) of 2/13/16. Resident #120 was coded as being severely impaired in cognitive status scoring 3 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #120 was coded as requiring	F 241	1. Resident #120 is wearing clothing garments that are free from residents name visible to the public. 2. Residents currently residing in the center have the potential to be affected. Observations have been conducted by the administrator/designee for residents currently residing in the center to ensure that residents are dressed in a dignified manor. 3. In-servicing has been provided to current employees by the DCS/designee to include grooming and dressing residents in a dignified manor while adhering to residents request. Random weekly observations will be conducted for five (5) residents five (5) times a week for three (3) months by the DCS/ designee to ensure that residents clothing are presentable and free from outside labeling.	6/22/16

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495362	A. BUILOING _____ B. WING _____	R-C 05/12/2016

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 241	Continued From page 38 extensive assistance from staff with dressing, toileting, personal hygiene, and bathing; and supervision with ambulation. On 5/12/16 at 9:00 a.m., Resident #120 was observed walking out of the dining room. She had a resident's name labeled on the back of her pink sweat pants; visible from a few feet away. On 5/12/16 at 10:15 a.m., Resident #120 was observed walking in the hallway. She was still wearing the pink sweat pants. On 5/12/16 at 12:45 p.m., Resident #120 was observed sitting in the dining room. She was still dressed in the pink sweat pants. On 5/12/16 at 10:41 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #5. When asked how to maintain dignity in regards to resident clothing she stated, "Clothing should be presentable, nothing revealing, and clean." When asked how clothing should be labeled she stated, "Inside the clothing." When asked what should happen if she noticed clothing labeled on the outside, she stated, "Well I wouldn't be able to throw the clothes away so I am not sure." At 10:44 a.m., LPN #5 looked at Resident #120's pants and said, "Well that's not her name. This resident passed away and the family donated her clothes." LPN #5 was not certain if a different resident's name labeled on the outside of Resident #120's pants was a dignity issue. On 5/12/16 at 11:00 a.m., an interview was conducted with LPN #3. When asked how to maintain dignity in regards to resident clothing she stated, "Make sure clothes are clean and neat." When asked how clothing should be	F 241	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 241	Continued From page 39 labeled she stated, "In the inside of the clothing." She stated that clothing should be labeled on the inside to maintain resident dignity. She stated that she would black out the name with a marker if she noticed a resident was wearing clothing that had their name written on the outside. Review of the facility's "Resident's Rights and Responsibilities" policy documents in part the following: "Privacy A. To be treated in a manner and in an environment that maintains or enhances your dignity, and respect in full recognition of individuality and privacy..." Mosby's Essentials for Nursing Assistants, 3rd edition, page 441, documented, "Quality of life is important for all persons with confusion and dementia. Nursing center residents have rights under OBRA. They may not know or be able to exercise their rights. However, the family knows the person's rights. They want those rights protected. They want respect and dignity for the loved one. The person has the right to privacy and confidentiality. Protect the person from exposure. Only those involved in the person's care are present for care and procedures. On 5/12/16 at 2:54 p.m., ASM (Administrative Staff Member) #2, the DON (Director of Nursing) was made aware of the above concerns. No further information was presented prior to exit.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	1. Resident #120 was assessed to reflect activities are individualized to meet the resident's interest. 2. Residents currently residing in the center have the potential to be affected. A review has been	6/22/16

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F 248	Continued From page 40 This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to provide activities that meet the resident's needs on one of three nursing units, Unit 3. The findings include: On 5/12/16 at 8:00 a.m., observation of the secured unit (Unit 3) was conducted. Twelve (12) residents were in the dining/activity room eating breakfast. Two nursing aides were in the room for supervision. On 5/12/16 between 9:00-9:48 a.m., 13 residents were in the dining/activity room sitting at the tables. Only one resident out of the 13 was finishing up breakfast. A television program was on the overhead TV that no one was watching. Two residents were observed falling asleep in their chairs. One to two nursing aides were observed in the room for supervision. At 9:28 a.m., a hospice aide from (Hospice Company) was observed sitting next to Resident #120. Resident #120 was restless sitting at a table with no activity to do. The hospice aide was observed to be on her phone for approximately five minutes before she stood up and left the room. Resident #120 remained sitting at the table with no activity or stimulation. Review of the activity calendar dated May 2016 documented the following for 5/12/16, "9:15 Coffee and Conversation." This activity did not occur. An observation was made on 5/12/16 at 9:48 to 10:30 a.m. of the activities room on the secured	F 248	conducted by the activities director/designee to ensure that appropriate activities programs have been identified to include resident interests and psychosocial well being. 3. In-servicing has been provided to the activities employees by the administrator/designee regarding provision of activities that meet the resident's interest and psychosocial well being. Random weekly observations will be conducted for five (5) residents per week for three (3) months by the administrator/designee to ensure that appropriate activities that meet the resident's individual interest and psychosocial well being. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 248	Continued From page 41 unit. There were 13 residents sitting at bare tables. There was one, CNA (certified nursing assistant) #10 in attendance. The television was on and was playing an old movie. No residents were watching the television. The residents were not speaking. At 9:56 a.m. a staff member came into the room, offered residents the opportunity to go to an exercise class and took six residents out of the room. CNA #10 went into the closet in the room and removed a wire toy with wooden colored balls on the wires and placed it in front of one of one of the residents. The resident did not touch the toy. CNA #10 stated, "They love (name of show), they'll sit there and laugh." The CNA changed the channel on the television the residents did not watch the program. At 10:35 a.m., on the secured unit, four residents were observed in the activity/dining room. These residents did not attend "Kevin Sings the Classics," an activity scheduled after the exercise activity in the main dining room. . The next two residents were observed talking amongst themselves. A TV program (game show) was on the overhead television that no one was watching. Review of the activity calendar dated 5/12/16 at 10:30 a.m. documented the following activity for residents on the secured unit, "Art Therapy." On 5/12/16 at 11:15 a.m., an interview was conducted with OSM #2, the activity director. When asked who was responsible for ensuring activities are planned and coordinated on the secured unit she stated, OSM #3, an activity assistant during the day shifts (7-3). When asked if the activity calendar should coincide with what the residents are actually doing she stated, "Well yes and no. Back there (secured unit) it can be very challenging to implement a program. We	F 248		

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F 248	Continued From page 42 adapt programs to how residents are cooperating or feeling. She was not sure why scheduled activity "Coffee and Conversation" was not implemented. On 5/12/16 at 11:18 p.m., an interview was conducted with OSM #3, the activity assistant. When asked when the scheduled activity "Coffee and Conversation" occurred she stated, "It did not occur." She stated that she is responsible for the morning smoke breaks for residents on other units, and was required to stand outside and supervise the smokers. She stated this cut into her planned activity on the secured unit at 9:15 a.m. When asked when the 10:30 a.m., scheduled activity program, "Art therapy" occurred she stated, "That did not occur either." She stated that she took most of the residents from the secured unit to the scheduled activity, "Exercise with Joel" and then "Kevin Sings the Classics" in the main dining room. She stated, "Because the group became so big, I had to stay to help supervise the residents in the main dining room." When asked what the remaining residents were supposed to do that stayed back on the secured unit she stated, "I told the CNA's to bring out puzzles, magazines, or whatever they wanted to keep them entertained." When asked why the CNAs did not provide art therapy she stated, "Honestly we do not have enough paint brushes for everyone. A lot of activities that I plan we cannot do because we do not have enough supplies for everyone." She stated that she was responsible for planning the activities for the entire month of May. She stated that she does not have training on residents with dementia but she researches activities at all different levels of cognitive status and function for the residents on the secured unit. She stated, "Not all residents have dementia on that unit but they have	F 248		

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F 248	Continued From page 43 behaviors. I think training would be helpful." OSM #3 stated that she only has training in childhood behavior. On 5/12/16 at 12:10 p.m., further interview was conducted with the OSM #2, the activity director. When asked if obtaining supplies was an issue to provide activities she stated, "Yes, I order supplies through two different companies and I am always told that (name of facility) does not pay their bills so I cannot obtain the supplies. We do what we can." She stated that she has brought this to administration's attention and there has been no resolution. She stated that she has to sometimes pay out of her own pocket for supplies. At 2:00 p.m., the activity calendar documented the following activity for 5/12/16, "What's Cooking." An observation was made in the activities room on the secured unit on 5/12/16 at 2:07 p.m. LPN #5 entered the room and stated to CNA #10, "Can we do some activities? They're getting restless." CNA #10 stated, "They're (activities) are supposed to be here soon to go cooking. We don't have no clothes to fold they took them all, all the magazines are gone too. Activities bring a bunch of clothes, washcloths, towels and socks and then they take them back." An observation of the activities room on the secured unit was conducted on 5/12/16 at 2:30 p.m. with ASM (administrative staff member) #1, the administrator and another surveyor. The activity taking place was called, "What's cooking." There was an aide in the room making peanut	F 248		

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F 248	Continued From page 44 butter and jelly sandwiches for the residents. When asked what did he, (the administrator) think the activity "What's Cooking?" would include, ASM #1 stated, "Some type of something, some kind of smell of some kind, try to get them stimulated. I don't smell anything that's stimulating." ASM #1 stated that he was not aware of a supply shortage but he has heard that some staff will take it upon themselves to buy things for the residents. He stated, "Staff should never pay for anything out of pocket. I tell them not to." Facility policy titled, "Developing a Calendar," documents in part, the following: "It is the policy of the (name of facility) activity department to offer sufficient programs to provide each resident the opportunity to spend adequate time in meaningful activities...1. Calendars should be inclusive of small groups, large programs, and one on one programs designed to stimulate residents' mental, physical, and psychosocial wellbeing...4. The Director of Therapeutic Recreation should consider the routines and schedules of the facility to avoid conflicts in attendance when designing the monthly activity calendar...7. Activities will be scheduled at appropriate times based on resident population availability, preferences and needs..." No further information was presented prior to exit.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	1. For Resident # 116 no longer resides in the facility, Social worker was notified of resident #130 threat to roommate 5/11/2016.	6/22/16

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F 250	Continued From page 45 This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide medically-related social services to two of 30 residents in the survey sample, Residents #116 and #130. 1. The facility staff failed to notify the social worker to provide services to Resident #116 following an incident in which Resident #130 threatened to harm Resident #116. 2. The facility staff failed to notify to the social worker to provide services to Resident #130 following an incident in which Resident #130 threatened to harm Resident #116. The findings include: 1. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD)	F 250	2. Residents currently residing in the center have the potential to be affected. A review has been conducted by the social services director/designee of social services documentation to ensure that social services documentation is present regarding resident to resident concerns. 3. In-servicing has been provided to staff/ social services concerning the importance of providing medically related social services following any resident concerns or resident to resident. A random weekly review will be completed for five (5) residents a weekly for three (3) months by the administrator/designee to ensure that social services has followed up on any resident concerns and provided assistance/support where needed. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 250	Continued From page 46 assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. On the following dates and times during the survey, Residents #116 and #130 were observed in the same room: 5/10/16 at 3:15 p.m.; 5/11/16 at 7:40 a.m. and 5:15 p.m. On 5/12/16 at 8:10 a.m., Resident #116 was observed to have been moved to a different room. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of the Admission Care Plan for Resident #116 dated 5/2/16 listed the following interventions under the heading "Falls/Safety/Elopement Risks: " Orthostatic hypotension precautions (to prevent low blood pressure when quickly sitting or standing up), ambulation devices as necessary, assess cognitive status as ability to ask for assistance,	F 250		

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	495362	A. BUILOING _____ B. WING _____	R-C 05/12/2016

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 250	Continued From page 47 assess resident footwear for fit and non-skid soles, encourage activity, safety checks, orthostatic BP (blood pressure) checks. Further review of the clinical record revealed no further evidence that the facility staff addressed Resident #130's threats to Resident #116, or referred Resident #116 to the social worker for follow up. On 5/11/16 at 3:55 p.m., LPN (licensed practical nurse) #2 was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated: "That could be considered abuse." She stated the residents are separated, and the staff should try to determine the cause of the conflict. She stated one of the residents should be assigned to another room in the facility. She stated the social worker would be informed of the incident at the next day's morning meeting of the interdisciplinary team. On 5/11/16 at 4:00 p.m., OSM (other staff member) #7, the social worker, was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated the residents should be immediately separated, and the safety of the resident who has been threatened should be ensured. She stated if the incident happens during a weekday, she would be notified immediately by the floor staff. She stated if the incident happened after hours, she would be told at the next morning meeting. She stated once she was informed of the incident, she would immediately go to interview both residents, and make sure a permanent room change had already been made. She said she would attempt to facilitate that room change if the incident occurred during office hours on a week day.	F 250		

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F 250	Continued From page 48 When shown the above referenced nurse's note regarding the threat made by Resident #130 to Resident #116, she stated: "I was not aware of that. I will go ahead and make sure they are separated." On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #3, the assistant director of nursing, was interviewed regarding the above referenced nurse's note. She was asked to provide the surveyor with an incident report and investigation regarding the threat Resident #130 made to Resident #116. She stated she did not have any further documentation regarding this incident. She stated she was aware the nurse working the floor when the incident occurred separated the residents immediately, and kept Resident #116 at the nurse's station until Resident #130 had gone to sleep. She stated when Resident #130 went to sleep, the facility staff assisted Resident #116 back into his bed (in the same room as Resident #130). On 5/11/16 at 6:10 p.m., LPN #11 was interviewed about the above referenced incident. She stated she was initially focused on Resident #116's fall and on assessing him for any injuries. She stated her assessment revealed no apparent injuries for Resident #116. She stated Resident #116 was being "very loud and unsteady" in his room, and Resident #130 said: "If you can't make him sit his [expletive] down, I will make him sit it down." She stated she put Resident #116 in a wheelchair and took him to sit at the nurse's station for the duration of the shift. She stated Resident #130 went to sleep, and she assisted Resident #116 back to his bed at that time. She stated she told the supervisor about this, and the supervisor told her to make sure the residents were separated and monitored to make sure	F 250		

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F 250	Continued From page 49 there were no other incidents. When asked if she recorded any of this information in the clinical record, she stated: "No, I didn't. I know I should have." When asked if she took any action to notify the social worker, she stated: "No, I did not." She stated she notified the unit manager of what happened when she returned to work the next morning. On 5/12/16 at 8:25, LPN #9, the unit manager, was interviewed regarding what she would do if she was notified of a resident threatening another resident. She stated the residents should be separated for safety. She stated she would alert the director of nursing. When asked if she would document any of her actions, she stated she would write a nurse's note about what happened and about any action she took. She stated the doctor and the RP (responsible party) should also be notified. When asked if she was told about an incident between Resident #116 and #130, she stated: "I didn't hear exactly what was said. I was just told they were arguing. I told the nurse we need to get them moved." When asked if this information was shared in the morning meeting at any point, she stated: "I brought the chart to the morning meeting on [the day following the incident] (5/10/16)." She stated: "There absolutely should have been an investigation." She stated she could not recall exactly what she had shared or what had been discussed at the morning meeting on 5/10/16. She stated she could not remember whether or not the social worker was in attendance at the morning meeting on 5/10/16. On 5/12/16 at 8:40 a.m., LPN #10, the evening supervisor on 5/9/16, was interviewed regarding the process to be followed when a resident was threatened by a roommate. She stated: "If it was	F 250		

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F 250	Continued From page 50 an actual threat, I would separate them and notify my boss. I would get witness statements from anyone who saw or heard anything, whether it was staff or residents." When asked how she determined a threat was an "actual" one, she stated: "An actual threat would be if a patient said they would hurt someone or had actually hurt someone." When asked about the above referenced incident between Resident #116 and Resident #130, she stated: "It was not brought to me as a threat." She said another staff member had told her Resident #130 had made a statement and we needed to do something about Resident #116 falling all over the place." She stated her concern was much more about the resident's unsteadiness and risk for falls. She stated a CNA (certified nursing assistant) sat with Resident #116 the remainder of the night shift to make sure he was safe. She stated: "We kept him safe all night. We monitored him all night." She stated if she had been told exactly what Resident #130 had said, she would have moved Resident #116 to a different room. When asked if she passed on any information about this incident to the next shift, she stated: "I would have passed it on myself. It was not on the 24-hour report. I should have put it on there." When asked if the incident should have been investigated as an incident of abuse, she stated: "Yes. Yes it should have. If I had known what really happened, I would have." When asked if the social worker had been notified of this incident, she stated: "I'm not sure. That would have been the right thing to do." On 5/11/16 at 5:50 p.m., ASM #1, ASM #2, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns.	F 250		

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F 250	Continued From page 51 A review of the facility policy entitled "Social Services" revealed, in part, the following: "Medically-related social services will be provided to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. Social Service personnel will identify the medically related social and emotional needs of residents and their families and provide for those needs by...Facilitating access to community resources/supports...Providing and/or arranging for needed counseling services; Identifying and seeking ways to support a resident's individual needs and preferences...Finding options that must meet the physical and emotional needs of each resident...Responding to changes in a resident's mental, physical or emotional status." A review of the job description entitled "Manager of Social Services" revealed, in part, the following: "Duties and Responsibilities...Provide/arrange for social work services as indicated by resident/family needs...Provide social work consultation to residents, families, and staff, as required." No further information was provided prior to exit. 2. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look	F 250		

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F 250	Continued From page 52 back period. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of Resident #130's clinical record revealed no evidence that the social worker was notified of the above referenced incident. On 5/11/16 at 4:00 p.m., OSM (other staff member) #7, the social worker, was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated the residents should be immediately separated, and the safety of the resident who has been	F 250		

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F 250	Continued From page 53 threatened should be ensured. She stated if the incident happens during a weekday, she would be notified immediately by the floor staff. She stated if the incident happened after hours, she would be told at the next morning meeting. She stated once she was informed of the incident, she would immediately go to interview both residents, and make sure a permanent room change had already been made. She said she would attempt to facilitate that room change if the incident occurred during office hours on a week day. When shown the above referenced nurse's note regarding the threat made by Resident #130 to Resident #116, she stated: "I was not aware of that. I will go ahead and make sure they are separated." On 5/12/16 at 1:10 p.m., LPN #8 was interviewed regarding this incident. She stated the social worker should have been notified, by way of the morning meeting, of this incident. She stated Resident #130 would have benefitted from a social worker assessment/visit. On 5/12/16 at 1:15 p.m., LPN #9, a unit manager, was interviewed regarding this incident. She stated the social worker usually attends the morning meeting. She stated the social worker had come to her late in the day on 5/11/16 (after being informed of the incident by the surveyor) and facilitated Resident #116's move to another room. On 5/12/16 at 3:10 p.m., ASM #1, ASM #2, ASM #3, ASM #4 and ASM #5, the corporate MDS consultant, were informed of these concerns. No further information was provided prior to exit.	F 250		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE	F 252		

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F 252	Continued From page 54 ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined that facility staff failed to provide a clean, comfortable, and homelike environment for one of 30 residents in the survey sample; Resident #129; and on one of three nursing units; Unit #3. 1. For Resident #129, facility staff failed to properly dispose a wheelchair cushion saturated in urine that left a strong odor in the resident's room for 1 hour and 15 minutes. 2. The facility staff failed to provide a clean and home-like activities room on the secured unit. The findings include: Resident #129 was admitted to the facility on 9/1/2015 with diagnoses that included but were not limited to high blood pressure, GERD (gastroesophageal reflux disease), hyperlipidemia, thyroid disorder, and Non-Alzheimer's dementia. Resident #129's most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 2/8/16. Resident #129 was coded as being severely impaired in cognition scoring 3 out of 15 on the BIMS (Brief Interview for Mental Status) exam.	F 252	1. Resident #129 has a wheelchair cushion free from odor. The secured unit is clean and has a home-like decorum. 2. Residents currently residing in the center have the potential to be affected. Observations were made of wheelchair cushions in the facility and were found to be free from odor. The secured unit has been updated with a home like feel. 3. In-servicing has been provided to the administrator/interdisciplinary team concerning having wheelchair cushions in good condition and free from odor. Staff has been educated on how to maintain a homelike environment by the DCS. Random audits will be conducted to ensure wheelchair cushions are adequate monthly x 3 months by central supply clerk or designee. 4. Findings from audits will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	6/22/16

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F 252	Continued From page 55 Resident #129 was coded as requiring extensive assistance from staff with dressing, personal hygiene, and bathing; independent with ambulation and eating; and supervision with toileting. Resident #129 was coded as being incontinent of bowel and bladder. On 5/12/16 at 8:20 a.m., observation of the Hanover (secured unit) was conducted. A strong urine odor was coming from Resident #129's room. The resident was not in the room and the bed was stripped. At 8:30 a.m., CNA (certified nursing assistant) #1 approached this surveyor. She stated, "The resident had an accident and I cleaned it up but I am waiting for housekeeping to come in and sanitize the bed. The resident was in the dining room earlier but she likes to walk into her room and pee on the bed or the floor." At 9:30 a.m., house cleaning was observed sanitizing Resident #129's bed and floor. The urine spell dissipated after the room was sanitized. On 5/12/16 at 11:30 p.m., there was a strong urine odor coming from Resident #129's room. On 5/12/16 at 1:00 p.m. the urine odor was still present. Review of Resident #129's care plan revised 2/25/16 documented the following under care area Behavior/Mood, "Socially inappropriate behavior (specify) urinates on floor..." Review of Resident #129's care plan revised 2/25/16 documented the following under care area Elimination GU (urinary), "Focus: The resident has altered bladder elimination...Approaches and Interventions: ...Check for incontinence. Wash, rinse and dry soiled areas..."	F 252		

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F 252	Continued From page 56 On 5/12/16 at 1: 00 p.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked how urine is cleaned after an incontinent episode she stated, "The CNA's pick up the urine or stool but then we call housekeeping to sanitize the room." When asked if this was done each time a resident has an incontinent episode she stated, "Yes." When asked if housekeeping responds right away she stated, "Yes, they are very good about cleaning the room right away." When asked what she could tell me about Resident #129 she stated, "She has a lot of incontinent episodes. She will pee on the floor, on her bed, take her soiled clothes off and hang them over the railing in the hallway. CNA #1 stated, "Her room still smells now. She actually just had an accident in her wheelchair when she was on her way back from activities. The activities assistant brought her back and her wheelchair cushion was all wet." When asked what time she came back from activities she stated, "Around lunch time. I cleaned her up but I didn't have time to get a large bag for her cushion so it is in the bathroom right now. When asked to see the wheelchair cushion, CNA #1 opened the bathroom door. The wheelchair cushion was observed on the floor in the corner of the bathroom soiled from urine. When asked why she did not have time to clean the cushion right away she stated, "It was during meal trays and I have to prioritize my tasks." When asked why leaving the soiled cushion in the corner of the bathroom was a concern she stated, "It is an infection control issue." When asked how she usually cleans wheelchair cushions she stated, "We bag them and give to housekeeping. I haven't had a chance to tell housekeeping yet." On 5/12/16 at 1:10 p.m., an interview was	F 252		

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F 252	Continued From page 57 conducted with OSM (Other Staff Member) #6, housekeeping. She stated that she has never been asked to clean a wheelchair cushion before. On 5/12/16 at 1: 15 p.m., an interview was conducted with CNA #17. When asked the process if a resident soils a wheelchair cushion she stated, "We usually will just throw them away and get a new cushion from therapy. Sometimes the cushions have a covering that will be carried to laundry." She stated the covering is carried in a plastic bag. On 5/12/16 at 1:18 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #6. When asked the process if a resident soils a wheelchair cushion she stated, "Contact maintenance and they will pressure wash the cushion or we throw away the cushion and ask therapy for a new one." She stated the cushion should always be bagged and never tossed on the floor. She stated soiled linens or cushions should never be placed on the floor because of cross contamination. On 5/12/16 at 2:24 p.m., an interview was conducted with OSM (Other Staff Member) #5 the maintenance director. He stated that the CNA's will wipe the wheelchair cushion after a resident has an incontinent episode and then will bag the cushion and give to maintenance to pressure wash. Facility policy titled, "Exposure Control Plan: Linen Handling" did not address the handling of soiled wheelchair cushions. On 5/12/16 at 2:54 p.m., ASM (Administrative Staff Member) #2, the DON (Director of Nursing) was made aware of the above findings. No	F 252		

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F 252	Continued From page 58 further information was presented prior to exit. 2. The facility staff failed to provide a home-like activities room on the secured unit. An observation of the activities room was made on 5/12/16 at 9:48 a.m. The room was painted beige and the wallpaper on three of the walls had been removed as the room was being renovated. There were maroon colored columns on the walls. The room had seven bare brown tables and 18 red and gold padded chairs. There were eight framed pictures on one wall; the pictures were all done in soft pastel colors. There were four crayon colored pictures on the back wall of the room. There was a television mounted to the wall at the front of the room. The floor was wood-grained with multiple scratches. There were three windows facing outside, the first window had blinds pulled 3/4 quarters the way up and closed, the second window had the blinds 1/4 quarter of the way up and closed and the third window had the blinds down and closed. Outside the room in the hall was a square brown table with the corners chipped and wood exposed. An observation was conducted of the activities room with CNA (certified nursing assistant) #1, the aide on 5/12/16 at 1:55 p.m. of the activities room. When asked to describe the room to this surveyor, CNA #1 stated, "It definitely needs painting over there (pointing to a wall). Did hear him (the maintenance director) this morning say he was going to do it. It needs pizzazz." When asked what that meant, CNA #1 stated, "It needs to be more decorative for the residents. Need a radio in here and it definitely needs to be bigger." When asked if the room was homelike, CNA #1 stated, "No, somewhat, a little bit only because of the TV." When asked what she thought about the table in the hall, CNA #1 stated, "It's a good idea	F 252		

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	495362	A. BUILDING _____ B. WING _____	R-C 05/12/2016

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F 252	Continued From page 59 for some (residents) to get away from the noise, but I'd have to say no, the ends are chipped but its sturdy and that's good." An observation was conducted of the activities room on 5/12/16 at 2:05 p.m. with LPN (licensed practical nurse) #5, the nurse assigned to the secured unit. When asked to describe the room to this surveyor, LPN #5 stated, "It's small, cluttered (by the tables). No space. The walls, they ' re in the process of painting but there's no color." When asked if it was homelike, LPN #5 stated, "No." When asked about the table in the hall, LPN #5 stated, "Yeah, the wood is chipped." An observation was conducted of the activities room with OSM (other staff member) #2, the activities director on 5/12/16 at 2:15 p.m. When asked to describe the activities room to this surveyor, OSM #2 stated, "This room is obviously on our dementia unit." When asked if it was homelike, OSM #2 stated, "No." An observation was conducted of the activities room on 5/12/16 at 2:28 p.m. with RN (registered nurse) #1, the unit manager. When asked to describe the activities room to this surveyor, RN #1 stated, "Like how it looks? It has the wallpaper on the walls and that burgundy color or whatever color that is, a TV." When asked if it was homelike, RN #1 stated, "No, I know we can do more, it's not stimulating." An observation was conducted of the activities room on 5/12/16 at 2:30 p.m. with ASM (administrative staff member) #1, the administrator. When asked to describe the room to this surveyor, ASM #1 stated, "Unpainted walls, the wallpaper has been taken off, the size of the room is great." When asked if it was homelike,	F 252		

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F 252	Continued From page 60 ASM #1 stated, "No ma'am, it's a work in progress." On 5/12/16 at 3:20 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 252		
{F 280} SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and revise the care plan for two of 30 residents in the survey sample, Residents #116 and #130.	(F 280)	1. Resident #116 no longer resides in the facility. Resident #130 care plan has been updated to included history of threatening others. 2. Residents currently residing in the facility have the potential to be affected. A review has been conducted by the MDS director/designee for residents with behavioral outburst in the past 30 days to ensure care plan is reflective of behavior. 3. In-servicing has been provided to the interdisciplinary team by the DCS/designee regarding updating plan off care with any changes to include behavioral outburst. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure that the any behavioral episodes have been added to the plan of care and plan revised as necessary.	6/22/16

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NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 280}	Continued From page 61 1. The facility staff failed to update the care plan for Resident #116 following a threat made by Resident #130 toward Resident #116 on 5/9/16. 2. The facility staff failed to update the care plan for Resident #130 following a threat made by Resident #130 toward Resident #116 on 5/9/16. The findings include: 1. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle	{F 280}	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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{F 280}	Continued From page 62 hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of the Admission Care Plan for Resident #116 dated 5/2/16 listed the following interventions under the heading "Falls/Safety/Elopement Risks: "Orthostatic hypotension precautions (to prevent low blood pressure when quickly sitting or standing up), ambulation devices as necessary, assess cognitive status as ability to ask for assistance, assess resident footwear for fit and non-skid soles, encourage activity, safety checks, orthostatic BP (blood pressure) checks. Further review of the clinical record revealed no further evidence that Resident #116's care plan was reviewed or revised after the incident on 5/9/16. On 5/12/16 at 2:45 p.m., LPN (licensed practical nurse) #3 was interviewed regarding the process for updating resident care plans following a resident to resident altercation. She stated that the care plans of both residents should be updated. She stated: "Unit managers are responsible for updating all of the care plans." On 5/12/16 at 2:47 p.m., LPN #18, a unit manager, was interviewed regarding the process	{F 280}		

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{F 280}	Continued From page 63	{F 280}		

of updating resident care plans following a resident to resident altercation. She stated: "If it's behavioral, the care plan should be updated." When asked who is responsible for updating resident care plans, she stated: "The nursing department." When asked to be more specific, she stated: "Either the nurses or me." When shown the nurse's note describing the above referenced incident, she stated that the care plan of both residents should have been updated.

On 5/12/16 at 3:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the corporate consultant, and ASM #5, the corporate MDS consultant, were informed of these concerns.

A review of the policy entitled "Plan of Care" revealed, in part, the following: "The Comprehensive plan of care is reviewed and updated at least quarterly, and as needed, by the interdisciplinary team and revisions are made by the interdisciplinary team to ensure needs are addressed and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it

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{F 280)	Continued From page 64 easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care. " 2. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted	{F 280)		

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{F 280}	Continued From page 65 on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." Further review of the comprehensive care plan for Resident #130 dated 10/1/15 and most recently updated on 1/8/16 revealed no further evidence that Resident #130's care plan was reviewed or revised after the incident on 5/9/16. On 5/12/16 at 2:45 p.m., LPN (licensed practical nurse) #3 was interviewed regarding the process for updating resident care plans following a resident to resident altercation. She stated that the care plans of both residents should be updated. She stated: "Unit managers are responsible for updating all of the care plans." On 5/12/16 at 2:47 p.m., LPN #18, a unit manager, was interviewed regarding the process of updating resident care plans following a resident to resident altercation. She stated: "If it's behavioral, the care plan should be updated." When asked who is responsible for updating resident care plans, she stated: "The nursing department." When asked to be more specific, she stated: "Either the nurses or me." When shown the nurse's note describing the above referenced incident, she stated that the care plan of both residents should have been updated. On 5/12/16 at 3:10 p.m., ASM #1, ASM #2, ASM #3, ASM #4 and ASM #5, the corporate MDS	{F 280}		

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{F 280}	Continued From page 66 consultant, were informed of these concerns. No further information was provided prior to exit.	{F 280}		6/22/16
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow professional standards of practice of documentation for two of 30 residents in the survey sample, Residents #116 and #130. 1. The facility staff failed to document their interventions to immediately separate Resident #116 from his roommate (Resident #130) following a threat made by Resident #130 toward Resident #116 on 5/9/16. 2. The facility staff failed to document Resident #130's threat to his roommate (Resident #116) on 5/9/16. The findings include: 1. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline.	F 281	1. Resident #116 no longer resides in the facility. Resident #130 is in a private room. For resident #130, no adverse effects related to room change. 2. Residents currently residing in the facility have the potential to be affected. A review has been conducted by the administrator/designee of incident reports within the last thirty (30) days to ensure that an investigation was conducted and interventions have been documented.	

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F 281	Continued From page 67 Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. On the following dates and times during the survey, Residents #116 and #130 were observed in the same room: 5/10/16 at 3:15 p.m.; 5/11/16 at 7:40 a.m. and 5:15 p.m. On 5/12/16 at 8:10 a.m., Resident #116 was observed to have been moved to a different room. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time."	F 281	3. In-servicing has been provided to the licensed nurses by the DCS/designee on proper and accurate documentation in the medical record. In-servicing has been provided to the interdisciplinary team by the DCS/designee regarding updating plan of care with any changes to include behavioral outburst with appropriate interventions to provide safety. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure that the any behavioral episodes have been added to the plan of care and immediate interventions in place. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 281	Continued From page 68 A review of the Admission Care Plan for Resident #116 dated 5/2/16 listed the following interventions under the heading "Falls/Safety/Elopement Risks: " Orthostatic hypotension precautions (to prevent low blood pressure when quickly sitting or standing up), ambulation devices as necessary, assess cognitive status as ability to ask for assistance, assess resident footwear for fit and non-skid soles, encourage activity, safety checks, orthostatic BP (blood pressure) checks. Further review of the clinical record revealed no further evidence that the facility staff addressed Resident #130's threats to Resident #116, or assessed Resident #116 for safety needs. The record revealed no evidence that Resident #116 was protected from further threats or harm from Resident #130. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #3, the assistant director of nursing, was interviewed regarding the above referenced nurse's note. She was asked to provide the surveyor with an incident report and investigation regarding the threat Resident #130 made to Resident #116. She stated that she did not have any further documentation regarding this incident. She stated that she was aware that the nurse working the floor when the incident occurred separated the residents immediately, and kept Resident #116 at the nurse's station until Resident #130 had gone to sleep. She stated that when Resident #130 went to sleep, the facility staff assisted Resident #116 back into his bed (in the same room as Resident #130). On 5/11/16 at 6:10 p.m., LPN #11 was interviewed about the above referenced incident. She stated that she was initially focused on	F 281		

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F 281	Continued From page 69	F 281		

Resident #116's fall and on assessing him for any injuries. She stated that her assessment revealed no apparent injuries for Resident #116. She stated that Resident #116 was being "very loud and unsteady" in his room, and that Resident #130 said: "If you can't make him sit his [expletive] down, I will make him sit it down." She stated that she put Resident #116 in a wheelchair and took him to sit at the nurse's station for the duration of the shift. She stated that Resident #130 went to sleep, and she assisted Resident #116 back to his bed at that time. She stated that she told the supervisor about this, and that the supervisor told her to make sure the residents were separated and monitored to make sure there were no other incidents. When asked if she recorded any of this information in the clinical record, she stated: "No, I didn't. I know I should have."

On 5/12/16 at 8:25, LPN #9, the unit manager, was interviewed regarding what she would do if she was notified of a resident threatening another resident. She stated that the residents should be separated for safety. She stated that she would alert the director of nursing. When asked if she would document any of her actions, she stated that she would write a nurse's note about what happened and about any action she took. She stated that the doctor and the RP should also be notified. When asked if she was told about an incident between Resident #116 and #130, she stated: "I didn't hear exactly what was said. I was just told they were arguing. I told the nurse that we need to get them moved." When asked if this information was shared in the morning meeting at any point, she stated: "I brought the chart to the morning meeting on [the day following the incident] (5/10/16)." She stated: "There absolutely should have been an

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 281	Continued From page 70 investigation." She stated she could not recall exactly what she had shared or what had been discussed at the morning meeting on 5/10/16. On 5/12/16 at 8:40 a.m., LPN #10, the evening supervisor on 5/9/16, was interviewed regarding the process to be followed when a resident was threatened by a roommate. She stated: "If it was an actual threat, I would separate them and notify my boss. I would get witness statements from anyone who saw or heard anything, whether it was staff or residents." When asked how she determined that a threat was an "actual" one, she stated: "An actual threat would be if a patient said that they would hurt someone or had actually hurt someone." When asked about the above referenced incident between Resident #116 and Resident #130, she stated: "It was not brought to me as a threat." She said that another staff member had told her that Resident #130 had made a statement and that we needed to do something about Resident #116 falling all over the place." She stated that her concern was much more about the resident's unsteadiness and risk for falls. She stated that a CNA (certified nursing assistant) sat with Resident #116 the remainder of the night shift to make sure he was safe. She stated: "We kept him safe all night. We monitored him all night." She stated that if she had been told exactly what Resident #130 had said, she would have moved Resident #116 to a different room. When asked if she passed on any information about this incident to the next shift, she stated: "I would have passed it on myself. It was not on the 24-hour report. I should have put it on there." When asked if the incident should have been investigated as an incident of abuse, she stated: "Yes. Yes it should have. If I had known what really happened, I would have."	F 281		

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F 281	Continued From page 71	F 281		

On 5/11/16 at 5:50 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns.

On 5/12/16 at 4:25 p.m., ASM #2 was asked to identify the facility's profession standard for clinical matters. She stated that the facility used the Lippincott clinical reference books for clinical standards.

A review of the facility policy entitled "Nurse Progress Notes" revealed, in part, the following: "A resident's progress shall be documented in the record as required. The nurse shall utilize the Progress Note to document resident progress. The note will be written legibly in black ink and shall include the following but not limited to: Date, Time (specific, not block time), Resident specific information, Signature with credentials."

No further information was provided prior to exit. According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: " Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."

The following quotation is found in Lippincott's

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F 281	Continued From page 72 Fundamentals of Nursing, 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received...Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it." 2. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16	F 281		

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F 281	Continued From page 73 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of Resident #130's clinical record revealed no nurses' notes after 5/2/16. The record contained no evidence of an altercation between Resident #130 and Resident #116 on 5/9/16. On 5/12/16 at 1:10 p.m., LPN #8 was interviewed regarding what should be documented if a resident makes a threat against another resident. She stated: "It should go in both resident charts. I would write a note in each of the charts. I would say what happened and who I called." On 5/12/16 at 1:15 p.m., LPN #9, a unit manager, was interviewed regarding what should be documented if a resident makes a threat against another resident. She stated that the events should be documented in both residents' progress notes. She stated that after the residents are separated and the physician and RP are notified, everything that happened with both residents should be documented. On 5/12/16 at 3:10 p.m., ASM #1, ASM #2, ASM #3, ASM #4 and ASM #5, the corporate MDS	F 281		

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F 281	Continued From page 74 consultant, were informed of these concerns. No further information was provided prior to exit.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined that facility staff failed to ensure services were provided by qualified staff for one of 30 residents in the survey sample; Resident #109; and facility staff failed to follow the plan of care for one of 30 residents in the survey sample; Resident #104. 1. Facility staff failed to ensure oxygen was administered by qualified staff for Resident #109. 2. The facility staff failed to follow the plan of care for one of 30 residents in the survey sample, Resident #104. The findings include: 1. Resident #109 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to heart failure, fracture of left femur, major depressive disorder, high cholesterol, dementia with behavioral disturbance and (1) COPD (Chronic Obstructive Pulmonary Disease- a progressive disease that makes it hard to breathe). Resident # 109's most recent MDS	F 282	1. Resident #109 is having oxygen therapy provided by qualified staff. Resident #104 no longer requires 1:1 supervision. 2. Residents currently residing in the facility have the potential to be affected. DCS/designee will in-service nursing staff /on regulations for administration of oxygen and following the residents plan of care. 1:1 supervision for residents 3. DCS/designee will perform random audits 3 times weekly for 3 months to ensure that oxygen therapy is being provided by qualified staff as per MD order. DCS/designee will conduct random audits to ensure that residents have a current care plans and that implementation is accurate. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	6/22/16

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(Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/19/16. Resident #109 was coded as being moderately impaired in cognitive status scoring 7 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #109 was coded as being totally dependent on staff with transfers, locomotion, toileting, personal hygiene and bathing; and extensive assistance with eating.

On 5/10/16 at 12:15 p.m., tour of the facility was conducted. At 12:50 p.m., Resident #109 was observed sitting up in bed. His nursing aide was right beside the bed feeding him lunch. Resident #109 was observed wearing a nasal cannula that was hooked up to an oxygen concentrator. The concentrator was off. When CNA #18 (certified nursing assistant) was asked where Resident #109's oxygen was hooked up to, she stated, "Oh, it is not even on." CNA #18 then flipped on the oxygen concentrator switch that automatically set the 02 rate to 2 LPM (liters per minute). CNA #18 stated that his oxygen is always supposed to be on. CNA #18 was not certain how long his oxygen was off.

Review of Resident #109's most recent POS (Physician Order Sheet) dated 5/1/16 documented the following order, "02 (oxygen) at 2L (liters)/min (minute) via nasal cannula continuous for shortness of breath." This order was initiated on 8/26/15.

Review of Resident #109's care plan revised 3/3/16 documented the following intervention under care area "Respiratory," "Oxygen as ordered (specify route, device, and liter flow) 2 LPM via NC (nasal cannula) continuously."

On 5/11/16 at 1:40 p.m., an interview was

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conducted with CNA #18. When asked the process if a resident's oxygen concentrator is not on, CNA #18 stated, "Cut it on immediately and tell the nurse. Oxygen to me is important." When asked if she is allowed to administer medications she stated, "No." When asked if she is allowed to administer oxygen she stated, "Was I not supposed to turn it on?"

On 5/11/16 at 1:51 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3. When asked who was responsible for ensuring oxygen is in place and functioning for a resident who utilizes 02, she stated, "The nurses." When asked who was allowed to administer oxygen she stated, "The nurses. Oxygen is considered a medication. We don't know if CNA's know the proper liters a resident has to be on."

On 5/11/16 at 2:00 p.m., an interview was conducted with CNA #19. When asked the process if she notices a resident's oxygen concentrator not on she stated, "Tell my charge nurse and inform them 02 is not on. I don't touch it because it is beyond my scope of practice. Oxygen is considered a medication."

Facility policy titled, "Oxygen Therapy," did not address the above concern.

On 5/12/16 at 2:54 p.m., ASM (Administrative Staff Member) #2, the DON (Director of Nursing) was made aware of the above findings.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse

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F 282	Continued From page 77 should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." No further information was presented prior to exit. (1) http://www.nhlbi.nih.gov/health/health-topics/topics/copd/ 2. Resident #104 was admitted to the facility on 9/9/15 and most recently readmitted on 1/16/16 with diagnoses including, but not limited to: Huntington disease*, difficulty swallowing, dementia, and psychosis. On the most recent MDS (minimum data set), a quarterly assessment with ARD (assessment reference date) 4/26/16, Resident #104 was coded as having both short term and long term memory difficulties, and as being severely cognitively impaired for making daily decisions. He was coded as requiring supervision of staff for walking in his room and on the unit. He was coded as being unsteady but able to stabilize without staff assistance for walking and turning around and facing the opposite direction while walking. He was coded as having had one fall with no injury during the look back period. He was coded as having exhibited no behaviors during the look back period. On 5/11/16 at approximately 7:30 a.m., Resident #104 was observed walking down the hall of his unit without 1:1 supervision by facility staff. He stopped in the middle of the hall and undressed.	F 282		

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F 282	Continued From page 78 On 5/11/16 between 7:50 a.m. and 7:55 a.m., Resident #104 was observed walking down the hall of his unit without evidence of 1:1 supervision by facility staff. He entered and exited multiple rooms of other residents during this time, as well as entering and exiting the activity room. On 5/11/16 at 8:00 a.m., Resident #104 was observed walking in the unit hallway unsupervised. He attempted to enter another resident's room. The surveyor observed Resident #104 being pushed out the doorway. On 5/11/16 at 8:07 a.m., Resident #104 was joined in his walk by CNA (certified nursing assistant) #2. She stated to another staff member: "I'm one on one with him today. You are need going to need to find somebody else to sit in the dining room with everyone else. On 5/11/16 at 8:25 a.m., Resident #104 was observed walking in the unit hall. CNA #2, who had been walking approximately 15 feet behind the resident, stopped at the medication cart to speak to another staff member. Resident #104 continued walking unsupervised down the hall, and attempted to enter the room from which he had been pushed earlier. He successfully opened the door to the room and entered, closing the door behind him. In approximately 90 seconds, CNA #2 began to search for Resident #104. She discovered him in the other room, and led him out of the room, closing the door behind her. A review of Resident #104's clinical record revealed the following nurses' notes: - "3/21/16 - 3-11 (evening shift) - Resident very agitated this shift, several attempts on redirecting resident but was unsuccessful."	F 282		

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F 282	Continued From page 79 - "4/17/16 - 7-3 (day shift) - Resisting and refusing care and difficulty with redirecting. Resident throws/sits on floor without injury when redirecting." - "4/19/16 - 3:15 p.m. - Resident status change from 1:1 to q 15 min (every 15 minute) safety checks. Will monitor need to either continue safety checks or return to 1:1 or d/c (discontinue) safety checks." - "4/19/16 - 4 p.m. - Resident was increasingly agitated. Unable to redirect by 1:1...Redirected out of others rooms." - "4/22/16 - 1:00 p.m. - RP (responsible party) was called. Left message to call facility concerning incident that involved [Resident #104] and another resident. " - "4/22/16 - 11:30 a.m. [late entry] - Resident walking thru (sic) halls disrobing and resistant to help. Resident combative upon approach when redirected from going into other resident's room. Resident laid (sic) in an unoccupied bed, redirected, however combative." A review of physician progress notes revealed a note written on 4/19/16 by the ASM (administrative staff member) #6, the medical director. Review of this note revealed, in part, the following: "The patient is a long-term resident of this facility, patient of [name of primary care physician]. He carries the diagnosis of Huntington chorea and behavior issues...I was asked [by the primary care physician] to review...Per staff, he paces around. He goes to other patient's room...Assessment and plan: Huntington chorea with dementia and behavior issues...Continue one-on-one sitter at the moment for fall precautions." A review of the nurse tech information kardex available to all staff for Resident #104 revealed a	F 282		

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F 282	Continued From page 80 box checked beside the word "Other" under the category of safety. Beside this was written "1:1." A review of the comprehensive care plan for Resident #104 dated 11/9/15 and most recently updated on 4/22/16 revealed, in part, the following: "Potential for impaired or inappropriate behaviors...as evidenced by violence to others, noncompliance with care or treatment regime, ineffective impulse control, wandering, aggressive behavior towards others, unsafe behaviors - running in hall, ambulating without assistance, gets into bed with other residents...increase 1:1 monitoring as needed." On 5/11/16 at 7:05 a.m., CNA #4 was interviewed regarding supervision Resident #104 should be receiving. She stated: "Most of the time, he has a one on one with him, even at night." When asked why he requires 1:1 supervision, she stated: "His biggest thing is getting into other people's beds." She stated that he falls easily and that he "agitates other residents." When asked how she knows a resident requires 1:1 supervision, she stated that she looks on the kardex. On 5/11/16 at 7:10 a.m., CNA #20 was interviewed regarding supervision Resident #104 should be receiving. She stated: "He is one on one." She stated that he requires 1:1 supervision "because he walks around, takes his clothes off and goes into other residents' rooms." On 5/11/16 at 1:00 p.m., LPN (licensed practical nurse) #11, the nurse taking care of Resident #104 on 5/11/16. When asked what kind of supervision he should be receiving, she stated: "I think he is one on one. I have never worked on this unit before today. I work for an agency - not	F 282		

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the facility." When asked how she becomes aware of what sort of supervision a resident requires, she stated: "I get report from the night nurse, or the schedule or assignment sheet should have it." When asked why Resident #104 was on 1:1 supervision precautions, she stated: "Behaviors. It might also be for safety." When asked the goals for 1:1 supervision for Resident #104, she stated: "To monitor what a resident is doing - so we will know exactly what is going on. It also could be to prevent his falls. You want to try to keep him safe from other residents, and to prevent an event with another resident." When asked if she had looked at Resident #104's care plan or kardex during that shift, she stated: "I have not had time."

On 5/11/16 at 1:30 p.m., ASM #6 was interviewed regarding 1:1 supervision for residents. He stated: "They may be wandering. They may be a fall risk. They may hit someone or be hit. You want to make sure they don't fall, so they don't hit someone, so they are not hit." When shown the above-referenced note and asked what he intended by one on one supervision he wrote in the note, he stated: "Close observation. He needs to be observed in front of your eyes. If he leaves the room, he needs to be supervised, observed." He stated that the resident needed to have someone watching him. He stated that another term for the 1:1 supervision would be "close observation."

On 5/11/16 at 1:45 p.m., RN (registered nurse) #1, the manager for Resident #104's unit, was interviewed regarding the process for assessing a resident's safety needs. She stated that the staff needs to know how residents are walking, if they are able to safely use a wheelchair, or if they are appropriately placed in the facility's dementia unit.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 82 When asked who determines what a resident needs regarding safety, she stated: "Either the people at the morning meeting, or, if it is an immediate need, the staff implements something right away and informs the team at the next morning meeting." When asked if she attends the morning meeting as a unit manager, she stated: "I just started going to them this week." When asked what 1:1 supervision means for residents, she stated that the 1:1 staff member should be within arm's reach of the resident at all times. When asked how this is communicated, she stated that she informs staff after a morning meeting, or, if it is an ongoing need, the 1:1 staff assignment is documented on the unit assignment sheet. She stated that Resident #104 should currently have a 1:1 staff assignment. When shown the care plan for Resident #104 she stated: "This means that we increase monitoring for him period. He should always have one on one." When asked why the resident needed 1:1 supervision, she stated: "We put him on one on one to protect him from others. He goes into different residents' rooms. He has been one on one for a long time." When asked if this information should be on the care plan and kardex, she stated: "I suppose." On 5/11/16 at 2:55 p.m., CNA #2 was interviewed regarding her care for Resident #104 that day. She stated that she had arrived at work at 7:00 a.m. She stated that she was originally scheduled to care for residents in four rooms of the unit for that shift. Then she was assigned to 1:1 care for Resident #104. Then she was assigned back to the original eight residents towards the end of her shift. When asked what time she began her 1:1 assignment with Resident #104, she stated: "It was between 8:00 (a.m.) and 8:30 (a.m.). I saw he didn't have anybody	F 282		

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with him, so I asked if I could be his sitter." She stated that from the time she arrived until she took over care for him between 8:00 a.m. and 8:30 a.m., the resident was unsupervised.

On 5/11/16 at 2:35 p.m., ASM #2, the director of nursing, was interviewed regarding the assessment of residents' safety needs. She stated: "We have to look at the whole person - at orders, diagnoses, observations. We have to figure out what the resident needs as a whole person." She stated that the nurse who originally admits a resident is responsible for the initial safety assessment and that the unit managers, morning meeting staff, and floor staff are responsible for providing ongoing assessments and implementing new interventions if needed. She stated that 1:1 supervision did not require a physician's order, and could be started as a nursing intervention. When asked the protocol for 1:1 supervision, she stated: "You need to be in sight of that resident. You should be able to visualize what that resident is doing." When asked if 1:1 staff needed to be within arm's reach of a resident, she stated: "It depends on the resident. If you don't trust them, if the need is there, then that's what you'd do." She stated that when CNAs (certified nursing assistants) are placed 1:1 with residents, "they are close enough to intervene." When asked specifically about the safety needs for Resident #104, she stated: "He was on one on one. I don't think he's on it now. I think [ASM #1, the executive director] made that decision. He reviewed all the one on ones and discontinued it."

On 5/11/16 at 3:10 p.m., ASM #1 was interviewed regarding his involvement in making decisions regarding 1:1 supervision for residents. He stated: "It was a while back. We had two or

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F 282	Continued From page 84 three people on one on one. I am not a nurse, but I told them we need to assess the need. I talked with [ASM #2]. I told them we needed to try it for a day, see how it goes. If we need it, we need it. If we don't we don't." He stated that within 24 hours, it was clear that Resident #104 needed the 1:1 supervision. "The next day, within 24 hours, he had another FRI (facility reported incident). It was clear he needed it." When asked if he knew whether Resident #104 was currently care planned for 1:1 supervision, he stated: "Yes. As far as I know. For now." When asked why, he stated: "Because of his aggression. He gets into everything." On 5/11/16 at 5:50 p.m., ASM #1, ASM #2, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns. A review of the facility policy entitled "Behavior Monitoring" revealed, in part, the following: "Residents demonstrating behaviors that place the resident at risk, or interfere with care or other residents will be monitored and interventions initiated as an individualized approach to minimizing behavior...Residents with active behaviors that place the resident at risk interfere with care, or compromise the quality of care or quality of life will be reviewed by the interdisciplinary team on a regularly scheduled time...Interdisciplinary team will review behaviors, causative factors/triggers and/or root cause to determine individualized interventions to minimize or eliminate the targeted behaviors. Resident's plan of care will be updated as needed." A review of the facility policy entitled "Plans of Care" revealed, in part, the following: "An interdisciplinary plan of care will be established for each resident and updated in accordance with	F 282		

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F 282	Continued From page 85 state and federal regulatory requirements and on as as-needed basis...The resident's plan of care encompasses many documents that are part of the resident's clinical record and may include, not only structured care plan documents, but may also include MARS (medication administration records), TARS (treatment administration records), physician orders, flow records, and/or legal documents that would drive the plan of care for the individual resident....Direct care staff should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary." *"Huntington disease is a progressive brain </art/large/side-view-of-brain.jpeg> disorder that causes uncontrolled movements, emotional problems, and loss of thinking ability (cognition). This information is taken from the website https://ghr.nlm.nih.gov/condition/huntington-disease. According to Mosby's Textbook for Long-Term Care Assistants, fourth edition, 2003. Page 144, "Safety is a basic need. Nursing center residents are at great risk for falls and other accidents....You need to know the factors that increase a person's risk of accidents and injury. You also need to follow the person's care plan."	F 282		
{F 309} SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		

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{F 309}	Continued From page 86 This Requirement is not met as evidenced by: Surveyor: Sharkey, Linda Based on observation, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to promote the highest level of well-being for three of 30 residents in the survey sample, Resident #114, Resident #121 and Resident #115. 1. For Resident #114 facility staff failed to complete a complete pain assessment when the resident complained of unrelieved pain. 2. Facility staff failed to follow physician orders during the administration of nasal spray for Resident #121. 3. Resident # 115's blood sugars were not completed as ordered by the physician on 5/7/16 and 5/8/16 at 9:00 p.m. The findings include: 1. Resident #114 was admitted to the facility on 4/26/16 with diagnoses that included but were not limited to: anxiety, dementia and bipolar disease*. The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date} of 5/3/16 coded the resident with a four out of 15 on the BIMS (brief interview of mental status} indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring	{F 309}	1. For resident #114, a pain assessment has been completed resident has effective pain management. Nasal spray for resident #121 is being administered as ordered by MD. Resident #115 blood sugars are being completed as per MD order. 2. Residents currently residing in the facility have the potential to be affected. A review will be conducted for residents receiving pain medications for the past 30 days to ensure pain assessments were completed and medication was effective. Observations were made for residents receiving nasal sprays and no deficient practice noted. A review of residents with orders for blood sugar monitoring over past 30 days will be conducted for completion as per MD order.	6/22/16

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{F 309}	Continued From page 87 assistance of one staff member for dressing. In Section J0400 -- Pain frequency it was documented that during the last five days in the look back period that the resident had pain, "frequently" and in Section J0600 -- Pain intensity the resident rated the pain as an eight out of 10 with ten being the worst pain she could imagine. Review of the resident's care plan signed and dated 5/2/16 documented in part, "4. Pain. Monitor pain. Administer pain medications as ordered. Eliminate or reduce causative factors." Review of the doctor's orders dated, 4/28/16 it was documented, "Acetaminophen (Tylenol) 325 mg (milligrams) 2 tabs (tablets) P.O. (by mouth) twice a day. dx (diagnosis): pain. Acetaminophen 325 mg 1 tab P.O. Q (every) 6 hrs (hours) as needed. dx: pain." Review of the Resident's MAR (medication administration record) documented, "Acetaminophen 325 mg 2 tabs P.O. twice a day do not exceed (4000 mg/24 hr) dx: pain. Acetaminophen 325 mg 1 tab P.O. Q6Hrs as needed. dx: pain." The Tylenol was documented as being given twice a day from 5/1/16 to 5/10/16. The Tylenol as needed had been given on four occasions: 5/3/16 at 7:00 p.m.; 5/4/16 at 3:30 a.m.; 5/5/16 at 7:50 a.m. and 5/7/16 at 3:30 p.m. There was no Tylenol as needed given on 5/10/16. Review of the Resident's every shift pain rating documented that the resident had pain on: 5/2/16 -- pain rating of four on the 7:00 to 3:00 p.m. shift; 5/3/16 -- pain rating six on the 7:00 to 3:00 p.m. shift; 5/4/16 -- pain rating eight on the 7:00 to 3:00 p.m. shift; and 5/10/16 -- pain rating five on the 7:00 a.m. to 3:00 p.m. shift. The	{F 309}	3. In-servicing will be provided to licensed staff by the DCS/designee on following MD orders to include blood glucose monitoring. b) Licensed nurses will be in-serviced on ensuring pain assessments are completed including quality descriptors prior to administering as needed pain medications and monitoring the effectiveness of the pain medication c) in-servicing has been provided by the DCS/designee to the licensed nurses on safe medication administration to include notification of refusal and explanation to MD for any treatment not provided. . Random weekly reviews will be conducted for five (5) residents weekly for three (3) months by the DCS/designee for the following: a) ensuring pain assessments are completed including quality descriptors prior to administering as needed pain medications and monitoring the effectiveness of the pain medication, b) safe medication administration is being followed during random medication administration observations weekly for 3 month to include blood glucose testing, nasal sprays and insulin.	

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(F 309)	Continued From page 88 remaining shifts rated the resident's pain as zero. Review of Resident #114's pain flow sheet documented, "5/7/16. 3:30 p.m. Site/location of Pain. R (with a circle around it) ribs. Intensity 6. Medication/Dose. Tylenol 650 mg. Intensity after intervention. 0." Further review of the clinical record for 5/2/16, 5/3/16, 5/4/16 and 5/10/16 did not evidence documentation about follow up on the resident's pain rating or any further pain assessments or interventions. Review of Resident #114's nurse's notes dated 5/10/16 and timed for 10:30 p.m. documented in part, "Resident c/o (complained of) having left side pain, resident holding left side stating "my side hurt bad." Resident received scheduled Tylenol for pain, continues to complain (of) pain + hold left side. Left a message on MD (medical doctor) answering service to call facility. At this time awaiting MD response." There was no documentation that the pain was further reassessed or managed. Review of the physician's orders signed and dated 5/11/16 at 1:00 p.m. documented, "X-ray Thoraco-lumbar Spine (arrow pointing to right) Back Pain. Tramadol*** 25 mg po (by mouth) BID (twice a day) PRN (as needed) Pain." An observation of Resident #114 was made on 5/11/16 at 1:05 p.m. The resident was standing in the hall with her right hand over her left side and she was rubbing her side. The resident volunteered that she was having pain and that she had had the pain since being admitted to the facility. The resident stated, "I don't like taking pain pills but I won't refuse them."	{F 309}	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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{F 309}	Continued From page 89 An interview was conducted on 5/11/16 at 4:08 p.m. with LPN (licensed practical nurse) #12. When asked how resident's pain was assessed, LPN #12 stated, "If they're verbal and able to answer, that's how I would assess it. If they are not verbal I check to see if it's sensory. I then give the pain med (medication), if it's not effective I go to the next step." When asked if Resident #114 complained of pain, LPN #12 stated, "I'm not sure if her pain is a physical pain or a psychological pain. She has never expressed any pain when I touch (her abdomen) it." An interview was conducted on 5/11/16 at 4:14 p.m. with LPN #8. When asked how resident's pain was assessed, LPN #8 stated, "Before I give then pain medication I try to change their position and make them comfortable. Once I give them pain medication and it's not working I call the M.D. and tell them what we did." LPN #8 did not verbalize that the resident was physically re-assessed. An interview was conducted on 5/11/16 at 4:20 p.m. with LPN (licensed practical nurse) #11, the nurse assigned to Resident #114's unit. When asked how she assessed the residents for pain, LPN #11 stated, "I will find out where the pain is located, if the patient can tell me I ask them to give me a one to ten pain rating or I look at the body movement or expression." When asked if she had noticed any non-verbal expressions from Resident #114, LPN #11 stated, "Once she was rubbing her stomach." When asked if she assessed the resident she stated she had not. A telephone interview was conducted on 5/11/15 at 5:12 p.m. with LPN (Licensed Practical Nurse) #15, the nurse who wrote the note on 5/10/16 at	{F 309}		

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{F 309}	Continued From page 90 10:30 p.m. When asked to review how she discovered that Resident #114 was having pain and what she did from there, LPN #15 stated, "A CNA came to me that the resident was having pain. The pain's not new, she received her scheduled Tylenol. I called the answering service (for the doctor); I was awaiting his phone call." When asked if she checked on the resident, LPN #15 didn't respond. When asked if she had passed on the information to the next shift, LPN #15 stated, "No I didn't put it on the 24 hour report, it's where I usually put it. I got busy and forgot about it." LPN #15 then stated, that she had worked 7:00 a.m. to 11:00 p.m. that day and the note was written at 10:30 a.m. not p.m. LPN #15 then stated, "I did speak to (name of doctor) around 6:00 p.m., He said he ordered an x-ray, she has arthritis and didn't want to do anything else." When asked if it was usual to take that many hours to get a call back from a physician, LPN #15 stated it did sometimes. LPN #15's nurse's note was read again, LPN #15 stated, "I wrote that? Well I'd have to see that note." At that point in the conversation the telephone call was disconnected. On 5/11/16 at 8:00 a.m. the nurse's notes for 5/10/16 were re-reviewed. It was documented on the time of 10:30 p.m. that the "p (for p.m.) was crossed out" and an "a (for a.m.)" was documented. A review of the nurse's notes for 5/11/16 documented in part, "Late entry for 5/10/16 at 6:15 p (p.m.) writer spoke with MD in re: (regarding) resident c/o having left side pain. MD stated "resident is currently taking scheduled tylenol and have breaking (sic) tylenol for pain, + a xray done prior stating resident have oseoarthritis (sic). No new orders at this time. No	{F 309}		

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{F 309}	Continued From page 91 further pain voiced." An observation of Resident #114 was made on 5/12/16 at 8:00 a.m. by two other surveyors. Resident #114 approached the surveyors and told them she was in pain. An observation of Resident #114 was made on 5/12/16 at 9:21 a.m. The resident was standing in the door way of her room. She was holding her left side and stated, "It hurts, they (the facility staff) said they're going to call the doctor." An interview was conducted on 5/12/15 at 9:47 a.m. with LPN (licensed practical nurse) #5, the nurse assigned to the unit that day. When asked how she assessed a resident's pain, LPN #5 stated, "Sometimes they're demented, some of them can tell you if they are in pain, if they look uncomfortable I'll ask." Resident #114 approached LPN #5 at that time rubbing her left side, "It hurts." LPN #5 stated, "It's still hurting? We'll try something else. I'm gonna give her, her Tramadol*." LPN #5 stated, "I look at the facial expression as well, I ask as well, if it's (the answer) yes I see if they have a pain med (medication) and give it. If not (no pain medication ordered) I call the doctor. I go back and ask them if they are feeling any better and ask them to rate it (the pain). If they can't rate it I go by facial expressions." When asked what she thought of Resident #114's complaint of pain, LPN #5 stated, "She's rubbing it (her side) it's clear she's hurting." An interview was conducted on 5/12/16 at 1:00 p.m. with LPN #8. When asked how a pain assessment was made, LPN #8 stated, "If the resident tells me they have pain, the first thing I do is watch their facial expressions and ask on a	{F 309}		

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{F 309}	Continued From page 92 scale of zero to ten what pain level they have with ten being the highest. Then I give the pain medication." When asked if she reassessed the resident's pain, LPN #8 stated, "I go back in 30 minutes to an hour and ask if it worked and what was their pain level if they still had pain. I'd then try something non-pharmacological, maybe massage, talk with them, turn them if they're immobile." When asked how would she would assess a resident rubbing their abdomen, LPN #8 stated, "First I'd get their vital signs (blood pressure, pulse, temperature and respirations) cause you're messing with the abdomen there. I would palpate the abdomen, it could be their appendix. I would listen to their bowel sounds, if they had bowel sound in all four quadrants, I would give them more pain medication and turn them." On 5/11/16 at 5:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Pain Management" documented in part, "Policy: Management of pain is individualized for each resident. Unrelieved pain has negative and psychological consequences, including the potential for threatening functional ability. The same pain control measures used for residents who are able to communicate should be used for residents unable to communicate their pain due to severe dementia, aphasia, or other causes. Process: Perform a pain assessment using the assessment form that is part of this protocol. Whenever possible, obtain all information from the resident. In some cases, use behavioral cues to gather information. Evaluate possible environmental positional or other case of pain.	{F 309}		

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(F 309)	Continued From page 93 (i.e. cold, temperatures, annoying noises, or uncomfortable position). Procedure: Whenever the results of a pain assessment reveal that a resident's pain is not under control, the attending physician should be notified...." No further information was provided prior to exit. 2. Resident #121 was admitted to the facility on 2/7/14 with diagnoses that included but were not limited to high blood pressure, muscle weakness, epilepsy, and heart failure. Resident #121's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/5/2016. Resident #121 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #121 was coded as requiring supervision with all ADLS (Activities of Daily Living). On 5/10/16 at 4:22 p.m., medication administration observation was conducted with LPN (licensed practical nurse) #2. At 4:23 p.m., LPN #2 prepared the following medications for Resident #121: (1) Ocean nasal spray 0.65% solution. (Saline nasal spray used to relieve congestion during a cold or nasal dryness inside the nasal passage.) At 4:23 p.m., LPN #2 was observed to instill one spray into each nostril for Resident #121. Review of Resident #121's POS (Physician Order Sheet) dated 5/1/16 through 5/31/16 revealed the following order: "Sea Soft 0.65% SPRAY...OCEAN NASAL SPRAY INSTILL 2	(F 309)		

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{F 309}	Continued From page 94 SPRAYS INTO BOTH NOSTRILS FOUR TIMES DAILY." On 5/10/16 at 4:58 p.m., LPN #2 approached this surveyor and stated, "How did I do?" When shared the above observation she stated, "Oh ok." She stated she did not realize that she only administered one drop. On 5/11/16 at 1:45 p.m., an interview was conducted with LPN # 3. When asked the process of administering medications to prevent error she stated, "Follow the five rights of medication administration. You should also check the medications with what is listed on the MAR (Medication Administration Record) and then again while you pop each medication into the cup." On 5/11/16 at 1:51 p.m., an interview was conducted with LPN #18, the unit manager. When asked the process of administering medication to prevent error she stated, "Follow the five rights of medication administration and check each medication card with the MAR and then again as you give the medications." On 5/12/16 at 2:54 p.m., ASM #2, the DON (Director of Nursing) was made aware of the above observations. Facility policy titled, "Medications-Oral Administration of," documents in part, the following: "...Compare unit/dose of medication on MAR. Read label on the container THREE (3) TIMES: BEFORE REMOVING the drug from the drawer; before handling the drug to the resident; and before discarding the package." The following information is provided in Basic	{F 309}		

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{F 309}	Continued From page 95	{F 309}		

Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication administration. A medication order is required for you to administer any medication to a patient. Once you receive and process a medication, place the physician's or health care provider's complete order on the appropriate medication form, the MAR. The MAR includes the patient's name, room, and bed number, as well as the names, dosages, frequencies, and routes of administration for each medication. When transcribing orders, ensure the names of medications, dosages, routes, and times are legible. The nurse checks all orders for accuracy and thoroughness. When orders are transcribed, the same information needs to be checked again by the nurse. It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. To ensure safe medication administration, be aware of the six rights of medication administration.

1. The right medication
2. The right dose
3. The right patient
4. The right route
5. The right time
6. The right documentation

No further information was presented prior to exit.

(1) This information was obtained from https://www.nlm.nih.gov/medlineplus/ency/article/003049.htm.

3. Resident #115 was admitted to the facility on 4/26/11 with diagnoses that included, but were not limited to: cancer, cirrhosis, hepatitis C, diabetes, hypertension, and gastroesophageal

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{F 309}	Continued From page 96 reflux disease. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 2/8/16. Resident # 115 was coded as scoring 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was cognitively intact Review of the clinical record revealed a physician order originally dated 2/1/16 and most recently signed by the physician on 4/1/16 documented: "CHECK BLOOD SUGAR AT BEDTIME CALL MD < 60 (less than 60) OR > 450 (greater than 450)" Review of Resident # 115's care plan implemented on 2/17/16 documented, under "Focus Category: Metabolic, Focus: The Resident is at Risk for Metabolic Complications Etiologies: Diabetes" Under "Goal: Resident will be free of signs or symptoms of Hypoglycemia or Hyperglycemia" Under "Approaches & Interventions: Monitor for S/S (signs/symptoms) of hypo or hyperglycemia; Blood Glucose levels as ordered/indicated" Review of the MAR (medication administration record) for May 2016 revealed no documentation that Resident # 115's blood sugar was checked on 5/7/16 & 5/8/16 at 9:00 p.m. During an interview on 5/11/16 at 3:45 p.m. with LPN (licensed practical nurse) # 2 the blanks for 5/7/16 and 5/8/16 at 9:00 p.m. on Resident # 115's MAR were reviewed. LPN # 2 stated, "If there were blanks then it wasn't done." On 5/11/16 at 5:15 p.m. an attempt was made to	{F 309}		

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(F 309)	Continued From page 97 speak to LPN # 4, the nurse identified as being responsible for the blanks on Resident # 115's MAR. This attempt was unsuccessful. During an interview on 5/12/16 at 8:45 a.m. with RN (registered nurse) # 3, a unit manager, the blanks for 5/7/16 and 5/8/16 at 9:00 p.m. on Resident # 115's MAR were reviewed. RN # 3 stated that the nurse should have put something in there - so there is no proof that the blood sugars were done. If there had been a problem one should have written a nurses note or made a notation on the back of the MAR. RN # 3 was asked if there is anywhere else in the clinical record where blood sugars might be recorded and RN # 3 revealed that there was not. During an interview on 5/12/16 at 9:50 a.m. with ASM (administrative staff member) # 1, the administrator, this concern was shared and any facility policies related to this issue were requested. During an interview on 5/12/16 at 10:20 a.m. with ASM # 3, the assistant director of nurses, ASM # 3 reported that she (ASM # 3) could find no documentation that Resident # 115's blood sugars were done on 5/7/16 and 5/8/16 at 9:00 p.m. Review of the facility policy: "Physician Orders" Under "Policy: A Clinical Nurse shall transcribe and review all physician orders to effect (sic) their implementation." No further information was provided prior to exit. In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry, Mosby, Inc; Page 419: "The physician is responsible for	(F 309)		

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{F 309}	Continued From page 98 directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." Potter and Perry's Fundamentals of Nursing, 7th edition, documents the following information on page 245: "Nursing assessment involves the collection and verification of data and the analysis of all data to establish a database about a client's perceived needs, health problems and responses to those health problems."	{F 309}		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care for a Foley catheter* in a manner to prevent infection for one of 30 residents in the survey sample, Resident #107. The facility staff failed to keep Resident #107's Foley catheter collection bag and tubing off the floor. The findings include:	F 315	1. Resident #107 Foley catheter collection bag is off the floor. 2. Residents that reside in the facility with a Foley catheters have the potential to be affected. Observations of other residents with Foley catheter collection bags did not reveal any that were touching the floor. 3. In-servicing will be provided to the nursing staff by the DCS/designee on the proper care of a Foley catheter to prevent infection. Random weekly reviews will be conducted for residents with Foley catheters to ensure infection control practices are being implemented by no catheter collection bags touching the floor. The review will be conducted weekly for three (3) months by the DCS/designee.	6/22/16

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F 315	Continued From page 99 Resident #107 was admitted to the facility on 11/1/10 and most recently readmitted on 4/15/16 with diagnoses including, but not limited to: end stage renal disease requiring dialysis, intellectual disability, diabetes, glaucoma, testicular cancer and blindness. On the most recent MDS (minimum data set), a 14-day Medicare assessment with ARD (assessment reference date) 4/19/16, Resident #107 was coded as being severely cognitively impaired for making daily decisions, having scored four out of 15 on the BIMS (Brief Interview for Mental Status). He was coded as having an indwelling catheter. On 5/10/16 at 12:30 p.m. and 3:25 p.m., and on 5/12/16 at 7:55 a.m., Resident #107 was observed lying in his bed with the blanket pulled over his head. At each observation, the catheter drainage bag and part of the catheter tubing were touching the floor. A review of the physician's orders revealed, in part, the following order, written 5/1/16: "Foley cath (catheter) 16 Fr (16 French - denotes size of catheter) for urinary retention. Foley catheter care q shift (each shift)." A review of the comprehensive care plan for Resident #107 dated 2/2/16 and updated on 5/9/16 revealed, in part, the following: "The resident has altered bladder elimination...cath (catheter care) as ordered and prn (as needed)." On 5/12/16 at 8:55 a.m., LPN (licensed practical nurse) #7 was interviewed regarding Resident #7's catheter drainage bag and tubing touching the floor. She stated: "It needs to be picked up. The bag and the bagging need to be changed. It should not be dragging the floor." When asked	F 315	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 315	Continued From page 100 why these items should not be in contact with the floor, she stated: "It is infection control. These residents are already prone to infection. The bag and tubing should not be in contact with the dirty floor." On 5/12/16 at 9:00 a.m., CNA (certified nursing assistant) #3 was asked what she would do if she entered a room and observed a resident's catheter drainage bag and catheter tubing in contact with the floor. She stated: "It can't be on the floor. I would go get the nurse because it can't be on the floor. It's an infection control thing." On 5/12/16 at 3:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the corporate consultant, and ASM #5, the corporate MDS consultant, were informed of these concerns. A review of the facility policy entitled "Catheterization, Male and Female Urinary" revealed, in part, the following: "Tubing must be off of the floor at all times." No further information was provided prior to exit. *"A soft, plastic or rubber tube that is inserted into the bladder to drain the urine." This information is taken from the website http://www.nlm.nih.gov/medlineplus/ency/article/003981.htm According to Fundamentals of Nursing, Lippincott Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling	F 315		

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F 315	Continued From page 101 Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage system: 2. Maintain an unobstructed urine flow. b. Urine should not be allowed to collect in tubing because free flow of urine must be maintained to prevent urinary tract infection. Improper drainage occurs when the tubing is kinked or twisted, allowing pools of urine to collect in the tubing. c. Keep the bag off the floor to prevent bacterial contamination."	F 315		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a safe environment for two of 30 residents in the survey sample, Residents #104 and #116. 1. The facility staff failed to provide supervision for Resident #104 according to his care plan. His care plan provided for 1:1 (one on one) supervision. However, on 5/11/16, Resident #104 was left unsupervised and wandered into other residents' rooms multiple times. 2. The facility staff failed to provide a safe environment for Resident #116 after his roommate (Resident #130) threatened to harm	{F 323}	1. Resident #104 is no longer on 1:1 supervision. Resident #116 no longer resides in the facility. No adverse reactions were noted to resident #104 or #116. 2. Residents residing in the facility have the potential to be affected by failure to implement safety protocols. No residents are on 1:1 supervision currently. No reports of residents being threatened by other residents. 3. Facility staff will be in-serviced on proper process for 1:1 supervision by DCS/designee. In-servicing has been provided to current employees by Administration on investigating abuse allegations. All facility reportable incidents will be audited by Administrator/designee x 3 months to ensure investigation was completed and resident is free from harm.	6/22/16

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{F 323}	Continued From page 102 him. The findings include: 1. Resident #104 was admitted to the facility on 9/9/15 and most recently readmitted on 1/16/16 with diagnoses including, but not limited to: Huntington disease*, difficulty swallowing, dementia, and psychosis. On the most recent MDS (minimum data set), a quarterly assessment with ARD (assessment reference date) 4/26/16, Resident #104 was coded as having both short term and long term memory difficulties, and as being severely cognitively impaired for making daily decisions. He was coded as requiring supervision of staff for walking in his room and on the unit. He was coded as being unsteady but able to stabilize without staff assistance for walking and turning around and facing the opposite direction while walking. He was coded as having had one fall with no injury during the look back period. He was coded as having exhibited no behaviors during the look back period. On 5/11/16 at approximately 7:30 a.m., Resident #104 was observed walking down the hall of his unit without 1:1 supervision by facility staff. He stopped in the middle of the hall and undressed. He was assisted by a facility staff member to put clothes back on within approximately 90 seconds. On 5/11/16 between 7:50 a.m. and 7:55 a.m., Resident #104 was observed walking down the hall of his unit without evidence of 1:1 supervision by facility staff. He entered and exited multiple rooms of other residents during this time, as well as entering and exiting the activity room. On 5/11/16 at 8:00 a.m., Resident #104 was	{F 323}	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the	

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{F 323}	Continued From page 103 observed walking in the unit hallway unsupervised. He attempted to enter another resident's room. The surveyor observed Resident #104 being pushed out the doorway. On 5/11/16 at 8:07 a.m., Resident #104 was joined in his walk by CNA (certified nursing assistant) #2. She stated to another staff member: "I'm one on one with him today. You are need going to need to find somebody else to sit in the dining room with everyone else. On 5/11/16 at 8:25 a.m., Resident #104 was observed walking in the unit hall. CNA #2, who had been walking approximately 15 feet behind the resident, stopped at the medication cart to speak to another staff member. Resident #104 continued walking unsupervised down the hall, and attempted to enter the room from which he had been pushed earlier. He successfully opened the door to the room and entered, closing the door behind him. In approximately 90 seconds, CNA #2 began to search for Resident #104. She discovered him in the other room, and led him out of the room, closing the door behind her. A review of Resident #104's clinical record revealed the following nurses' notes: - "3/21/16 - 3-11 (evening shift) - Resident very agitated this shift, several attempts on redirecting resident but was unsuccessful." - "4/17/16 - 7-3 (day shift) - Resisting and refusing care and difficulty with redirecting. Resident throws/sits on floor without injury when redirecting." - "4/19/16 - 3:15 p.m. - Resident status change from 1:1 to q 15 min (every 15 minute) safety checks. Will monitor need to either continue safety checks or return to 1:1 or d/c (discontinue)	{F 323}		

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{F 323}	Continued From page 104 safety checks." - "4/19/16 - 4 p.m. - Resident was increasingly agitated. Unable to redirect by 1:1...Redirected out of others rooms." - "4/22/16 - 1:00 p.m. - RP (responsible party} was called. Left message to call facility concerning incident that involved [Resident #104] and another resident. " - "4/22/16 - 11:30 a.m. [late entry] - Resident walking thru {sic} halls disrobing and resistant to help. Resident combative upon approach when redirected from going into other resident's room. Resident laid {sic} in an unoccupied bed, redirected, however combative." A review of physician progress notes revealed a note written on 4/19/16 by the ASM (administrative staff member} #6, the medical director. Review of this note revealed, in part, the following: "The patient is a long-term resident of this facility, patient of [name of primary care physician]. He carries the diagnosis of Huntington chorea and behavior issues...I was asked [by the primary care physician] to review...Per staff, he paces around. He goes to other patient's room...Assessment and plan: Huntington chorea with dementia and behavior issues...Continue one-on-one sitter at the moment for fall precautions." A review of the nurse tech information kardex available to all staff for Resident #104 revealed a box checked beside the word "Other" under the category of safety. Beside this was written "1:1." A review of the comprehensive care plan for Resident #104 dated 11/9/15 and most recently updated on 4/22/16 revealed, in part, the following: "Potential for impaired or inappropriate behaviors...as evidenced by violence to others,	{F 323}		

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{F 323}	Continued From page 105 noncompliance with care or treatment regime, ineffective impulse control, wandering, aggressive behavior towards others, unsafe behaviors - running in hall, ambulating without assistance, gets into bed with other residents...increase 1:1 monitoring as needed." On 5/11/16 at 7:05 a.m., CNA #4 was interviewed regarding supervision Resident #104 should be receiving. She stated: "Most of the time, he has a one on one with him, even at night." When asked why he requires 1:1 supervision, she stated: "His biggest thing is getting into other people's beds." She stated he falls easily and he "agitates other residents." When asked how she knows a resident requires 1:1 supervision, she stated she looks on the kardex. On 5/11/16 at 7:10 a.m., CNA #20 was interviewed regarding supervision Resident #104 should be receiving. She stated: "He is one on one." She stated he requires 1:1 supervision "because he walks around, takes his clothes off and goes into other residents' rooms." On 5/11/16 at 1:00 p.m., LPN (licensed practical nurse) #11, the nurse taking care of Resident #104 on 5/11/16. When asked what kind of supervision he should be receiving, she stated: "I think he is one on one. I have never worked on this unit before today. I work for an agency - not the facility." When asked how she becomes aware of what sort of supervision a resident requires, she stated: "I get report from the night nurse, or the schedule or assignment sheet should have it." When asked why Resident #104 was on 1:1 supervision precautions, she stated: "Behaviors. It might also be for safety." When asked the goals for 1:1 supervision for Resident #104, she stated: "To monitor what a resident is	{F 323}		

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{F 323}	Continued From page 106	{F 323}		

doing - so we will know exactly what is going on. It also could be to prevent his falls. You want to try to keep him safe from other residents, and to prevent an event with another resident."

On 5/11/16 at 1:30 p.m., ASM #6 was interviewed regarding 1:1 supervision for residents. He stated: "They may be wandering. They may be a fall risk. They may hit someone or be hit. You want to make sure they don't fall, so they don't hit someone, so they are not hit." When shown the above-referenced note and asked what he intended by one on one supervision he wrote in the note, he stated: "Close observation. He needs to be observed in front of your eyes. If he leaves the room, he needs to be supervised, observed." He stated the resident needed to have someone watching him. He stated another term for the 1:1 supervision would be "close observation."

On 5/11/16 at 1:45 p.m., RN {registered nurse) #1, the manager for Resident #104's unit, was interviewed regarding the process for assessing a resident's safety needs. She stated the staff needs to know how residents are walking, if they are able to safely use a wheelchair, or if they are appropriately placed in the facility's dementia unit. When asked who determines what a resident needs regarding safety, she stated: "Either the people at the morning meeting, or, if it is an immediate need, the staff implements something right away and informs the team at the next morning meeting." When asked if she attends the morning meeting as a unit manager, she stated: "I just started going to them this week." When asked what 1:1 supervision means for residents, she stated the 1:1 staff member should be within arm's reach of the resident at all times. When asked how this is communicated, she

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{F 323}	Continued From page 107 stated she informs staff after a morning meeting, or, if it is an ongoing need, the 1:1 staff assignment is documented on the unit assignment sheet. She stated Resident #104 should currently have a 1:1 staff assignment. When shown the care plan for Resident #104 she stated: "This means that we increase monitoring for him period. He should always have one on one." When asked why the resident needed 1:1 supervision, she stated: "We put him on one on one to protect him from others. He goes into different residents' rooms. He has been one on one for a long time." On 5/11/16 at 2:55 p.m., CNA #2 was interviewed regarding her care for Resident #104 that day. She stated she had arrived at work at 7:00 a.m. She stated she was originally scheduled to care for residents in four rooms of the unit (eight residents) for that shift. Then she was assigned to 1:1 care for Resident #104. Then she was assigned back to the original eight residents towards the end of her shift. When asked what time she began her 1:1 assignment with Resident #104, she stated: "It was between 8:00 (a.m.) and 8:30 (a.m.). I saw he didn't have anybody with him, so I asked if I could be his sitter." She stated from the time she arrived until she took over care for him between 8:00 a.m. and 8:30 a.m., the resident was unsupervised. On 5/11/16 at 2:35 p.m., ASM #2, the director of nursing, was interviewed regarding the assessment of residents' safety needs. She stated: "We have to look at the whole person - at orders, diagnoses, observations. We have to figure out what the resident needs as a whole person." She stated the nurse who originally admits a resident is responsible for the initial safety assessment and the unit managers,	{F 323}		

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{F 323}	Continued From page 108 morning meeting staff, and floor staff are responsible for providing ongoing assessments and implementing new interventions if needed. She stated 1:1 supervision did not require a physician's order, and could be started as a nursing intervention. When asked the protocol for 1:1 supervision, she stated: "You need to be in sight of that resident. You should be able to visualize what that resident is doing." When asked if 1:1 staff needed to be within arm's reach of a resident, she stated: "It depends on the resident. If you don't trust them, if the need is there, then that's what you'd do." She stated when CNAs (certified nursing assistants) are placed 1:1 with residents, "they are close enough to intervene." When asked specifically about the safety needs for Resident #104, she stated: "He was on one on one. I don't think he's on it now. I think [ASM #1, the executive director] made that decision. He reviewed all the one on ones and discontinued it." On 5/11/16 at 3:10 p.m., ASM #1 was interviewed regarding his involvement in making decisions regarding 1:1 supervision for residents. He stated: "It was a while back. We had two or three people on one on one. I am not a nurse, but I told them we need to assess the need. I talked with [ASM #2]. I told them we needed to try it for a day, see how it goes. If we need it, we need it. If we don't we don't." He stated within 24 hours, it was clear that Resident #104 needed the 1:1 supervision. "The next day, within 24 hours, he had another FRI (facility reported incident). It was clear he needed it." When asked if he knew whether Resident #104 was currently care planned for 1:1 supervision, he stated: "Yes. As far as I know. For now." When asked why, he stated: "Because of his aggression. He gets into everything."	{F 323}		

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{F 323}	Continued From page 109 On 5/11/16 at 5:50 p.m., ASM #1, ASM #2, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns. Policies regarding behavior management and resident safety were requested. A review of the facility policy entitled "Behavior Monitoring" revealed, in part, the following: "Residents demonstrating behaviors that place the resident at risk, or interfere with care or other residents will be monitored and interventions initiated as an individualized approach to minimizing behavior...Residents with active behaviors that place the resident at risk interfere with care, or compromise the quality of care or quality of life will be reviewed by the interdisciplinary team on a regularly scheduled time...Interdisciplinary team will review behaviors, causative factors/triggers and/or root cause to determine individualized interventions to minimize or eliminate the targeted behaviors. Resident's plan of care will be updated as needed." No further information was requested prior to exit. *"Huntington disease is a progressive brain </art/large/side-view-of-brain.jpeg> disorder that causes uncontrolled movements, emotional problems, and loss of thinking ability (cognition). This information is taken from the website https://ghr.nlm.nih.gov/condition/huntington-disease. 2. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of	{F 323}		

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(F 323)	Continued From page 110 depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. On the following dates and times during the survey, Residents #116 and #130 were observed in the same room: 5/10/16 at 3:15 p.m.; 5/11/16 at 7:40 a.m. and 5:15 p.m. On 5/12/16 at 8:10 a.m., Resident #116 was observed to have been moved to a different room. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call	(F 323)		

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{F 323}	Continued From page 111 placed to MD. Awaiting return call @ (at) this time." A review of the Admission Care Plan for Resident #116 dated 5/2/16 listed the following interventions under the heading "Falls/Safety/Elopement Risks": Orthostatic hypotension precautions (to prevent low blood pressure when quickly sitting or standing up), ambulation devices as necessary, assess cognitive status as ability to ask for assistance, assess resident footwear for fit and non-skid soles, encourage activity, safety checks, orthostatic BP (blood pressure) checks. Further review of the clinical record revealed no further evidence that the facility staff addressed Resident #130's threats to Resident #116, or assessed Resident #116 for safety needs. The record revealed no evidence that Resident #116 was protected from further threats or harm from Resident #130. On 5/11/16 at 3:55 p.m., LPN (licensed practical nurse) #2 was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated: "That could be considered abuse." She stated the residents are separated, and the staff should try to determine the cause of the conflict. She stated one of the residents should be assigned to another room in the facility. She stated the social worker would be informed of the incident at the next day's morning meeting of the interdisciplinary team. On 5/11/16 at 4:00 p.m., OSM (other staff member) #7, the social worker, was interviewed regarding the procedure to be followed when one resident threatens another resident. She stated	{F 323}		

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{F 323}	Continued From page 112 the residents should be immediately separated, and the safety of the resident who has been threatened should be ensured. She stated if the incident happens during a weekday, she would be notified immediately by the floor staff. She stated if the incident happened after hours, she would be told at the next morning meeting. She stated once she was informed of the incident, she would immediately go to interview both residents, and make sure a permanent room change had already been made. She said she would attempt to facilitate that room change if the incident occurred during office hours on a week day. When shown the above referenced nurse's note regarding the threat made by Resident #130 to Resident #116, she stated: "I was not aware of that. I will go ahead and make sure they are separated." On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #3, the assistant director of nursing, was interviewed regarding the above referenced nurse's note. She was asked to provide the surveyor with an incident report and investigation regarding the threat Resident #130 made to Resident #116. She stated she did not have any further documentation regarding this incident. She stated she was aware the nurse working the floor when the incident occurred separated the residents immediately, and kept Resident #116 at the nurse's station until Resident #130 had gone to sleep. She stated when Resident #130 went to sleep, the facility staff assisted Resident #116 back into his bed (in the same room as Resident #130). On 5/11/16 at 6:10 p.m., LPN #11 was interviewed about the above referenced incident. She stated she was initially focused on Resident #116's fall and on assessing him for any injuries.	{F 323}		

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{F 323}	Continued From page 113 She stated her assessment revealed no apparent injuries for Resident #116. She stated Resident #116 was being "very loud and unsteady" in his room, and Resident #130 said: "If you can't make him sit his [expletive] down, I will make him sit it down." She stated she put Resident #116 in a wheelchair and took him to sit at the nurse's station for the duration of the shift. She stated Resident #130 went to sleep, and she assisted Resident #116 back to his bed at that time. She stated she told the supervisor about this, and the supervisor told her to make sure the residents were separated and monitored to make sure there were no other incidents. When asked if she recorded any of this information in the clinical record, she stated: "No, I didn't. I know I should have." When asked if she took any action to notify the social worker, she stated: "No, I did not." She stated she notified the unit manager of what happened when she returned to work the next morning. On 5/12/16 at 8:25, LPN #9, the unit manager, was interviewed regarding what she would do if she was notified of a resident threatening another resident. She stated the residents should be separated for safety. She stated she would alert the director of nursing. When asked if she would document any of her actions, she stated she would write a nurse's note about what happened and about any action she took. She stated the doctor and the RP (responsible party) should also be notified. When asked if she was told about an incident between Resident #116 and #130, she stated: "I didn't hear exactly what was said. I was just told they were arguing. I told the nurse we need to get them moved." When asked if this information was shared in the morning meeting at any point, she stated: "I brought the chart to the morning meeting on [the day following the	{F 323}		

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{F 323}	Continued From page 114	{F 323}		

incident] (5/10/16}." She stated: "There absolutely should have been an investigation." She stated she could not recall exactly what she had shared or what had been discussed at the morning meeting on 5/10/16.

On 5/12/16 at 8:40 a.m., LPN #10, the evening supervisor on 5/9/16, was interviewed regarding the process to be followed when a resident was threatened by a roommate. She stated: "If it was an actual threat, I would separate them and notify my boss. I would get witness statements from anyone who saw or heard anything, whether it was staff or residents." When asked how she determined a threat was an "actual" one, she stated: "An actual threat would be if a patient said they would hurt someone or had actually hurt someone." When asked about the above referenced incident between Resident #116 and Resident #130, she stated: "It was not brought to me as a threat." She said another staff member had told her Resident #130 had made a statement and we needed to do something about Resident #116 falling all over the place." She stated her concern was much more about the resident's unsteadiness and risk for falls. She stated a CNA (certified nursing assistant) sat with Resident #116 the remainder of the night shift to make sure he was safe. She stated: "We kept him safe all night. We monitored him all night." She stated if she had been told exactly what Resident #130 had said, she would have moved Resident #116 to a different room. When asked if she passed on any information about this incident to the next shift, she stated: "I would have passed it on myself. It was not on the 24-hour report. I should have put it on there." When asked if the incident should have been investigated as an incident of abuse, she stated: "Yes. Yes it should have. If I had known what

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{F 323}	Continued From page 115 really happened, I would have." On 5/11/16 at 5:50 p.m., ASM #1, ASM #2, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns. Policies regarding resident safety/protection from abuse were requested. A review of the facility policy entitled "Resident Abuse" revealed, in part, the following: "An abusive act is any act or omission, which may cause or causes actual physical, psychological or emotional harm or injury to a resident...Any action that may cause or causes actual physical, psychological or emotional harm, which is not caused by simple negligence, constitutes abuse...All reported events {bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services...Any employee who witnesses or who has knowledge of an act of abuse or an allegation of abuse to a resident is obligated to report such information immediately to their supervisor." No further information was provided prior to exit.	{F 323}		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	1.Resident #109 is having oxygen therapy administered by qualified personnel. 2.Residents that reside in the facility with oxygen have the potential to be affected. DCS/designee will complete an audit of residents with orders for oxygen to ensure administration is provided by licensed personnel.	6/22/16

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 328	Continued From page 116 This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined that facility staff failed to safely administer oxygen for one of 30 residents in the survey sample; Resident #109. Facility staff failed to safely administer oxygen to Resident #109 when his CNA turned on the oxygen concentrator at a rate of 2 LPM (Liters Per Minute). The findings include: Resident #109 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to heart failure, fracture of left femur, major depressive disorder, high cholesterol, dementia with behavioral disturbance and (1) COPD (Chronic Obstructive Pulmonary Disease- a progressive disease that makes it hard to breathe). Resident # 109's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/19/16. Resident #109 was coded as being moderately impaired in cognitive status scoring 7 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #109 was coded as being totally dependent on staff with transfers, locomotion, toileting, personal hygiene and bathing; and extensive assistance with eating. On 5/10/16 at 12:15 p.m., tour of the facility was conducted. At 12:50 p.m., Resident #109 was observed sitting up in bed. His nursing aide was right beside the bed feeding him lunch. Resident #109 was observed wearing a nasal cannula that was hooked up to an oxygen concentrator. The concentrator was off. When CNA #18 (certified	F 328	3.DCS/designee will in-service nursing staff on safe administration of oxygen. Random audits will be completed weekly x 3 months by DCS/designee to ensure oxygen therapy is being provided as ordered by qualified personnel. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the	

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	495362	A. BUILDING _____ B. WING _____	R-C 05/12/2016

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F 328	Continued From page 117 nursing assistant), was asked where Resident #109's oxygen was hooked up to she stated, "Oh, it is not even on." CNA #18 then flipped on the oxygen concentrator switch that automatically set the 02 rate to 2 LPM (liters per minute). CNA #18 stated that his oxygen is always supposed to be on. CNA #18 was not certain how long his oxygen was off. Review of Resident #109's most recent POS (Physician Order Sheet) dated 5/1/16 documented the following order, "02 (oxygen) at 2L (liters)/min (minute) via nasal cannula continuous for shortness of breath." This order was initiated on 8/26/15. Review of Resident #109's care plan revised 3/3/16 documented the following intervention under care area "Respiratory," "Oxygen as ordered (specify route, device, and liter flow) 2 LPM via NC (nasal cannula) continuously." On 5/11/16 at 1:40 p.m., an interview was conducted with CNA #18. When asked the process if a resident's oxygen concentrator is not on, CNA #18 stated, "Cut it on immediately and tell the nurse. Oxygen to me is important." When asked if she is allowed to administer medications she stated, "No." When asked if she is allowed to administer oxygen she stated, "Was I not supposed to turn it on?" On 5/11/16 at 1:51 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3. When asked who was responsible for ensuring oxygen is in place and functioning for a resident who utilizes 02, she stated, "The nurses." When asked who was allowed to administer oxygen she stated, "The nurses. Oxygen is considered a medication. We don't know if CNA's	F 328		

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F 328	Continued From page 118 know the proper liters a resident has to be on." On 5/11/16 at 2:00 p.m., an interview was conducted with CNA #19. When asked the process if she notices a resident's oxygen concentrator not on she stated, "Tell my charge nurse and inform them 02 is not on. I don't touch it because it is beyond my scope of practice. Oxygen is considered a medication." Facility policy titled, "Oxygen Therapy," did not address the above concern. On 5/12/16 at 2:54 p.m., ASM (Administrative Staff Member) #2, the DON (Director of Nursing) was made aware of the above findings. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." No further information was presented prior to exit. (1) http://www.nhlbi.nih.gov/health/health-topics/topics/copd/	F 328		
F 441 SS=E	4B3.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	1. Resident #124 no longer has loose stools. No adverse affects were noted to resident #126, #127, #128, #129 or #107 due to poor infection control practices.	6/22/16

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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NAME OF PROVIOER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
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F 441	Continued From page 119 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services in a manner to prevent	F 441	2. Residents in the facility have the potential to be affected by poor infection control practices. Staff observations have been conducted after providing care and handwashing is being performed properly as well as disposal of gloves, wheelchair cushions have been audited and none were found to be soiled. No Foley catheter tubing was noted to be touching the floor. 3. Nursing staff and CNAs will be in-serviced on preventing the spread of infection and isolation precautions by DCS/designee to ensure handwashing is done after each resident contact and proper disposal of gloves, wheelchair cushions will be monitored weekly x 3 months to ensure no cushions are saturated with urine, residents with foley catheters will be observed weekly x 3 months to ensure the catheter collection bag is off of the floor.	

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F 441	Continued From page 120 infections for six of 30 residents in the survey sample, Resident #124, Resident #126, Resident #127, Resident #129, Resident #128 and Resident #107. 1. The facility staff failed to place Resident #124 in contact isolation when she was demonstrating signs and symptoms of having C. Diff (clostridium difficile). 2. For Resident #126 facility staff failed to wash their hands after providing personal care to the resident's roommate and before serving the resident lunch. 3. For Resident #127 facility staff failed to wash their hands after providing personal care. 4. For Resident #129, facility staff failed to dispose of a wheelchair cushion saturated in urine in a sanitary manner. 5. Facility staff failed to dispose three boxes of gloves that were contaminated by Resident #128. 6. The facility staff failed to keep Resident #107's Foley catheter* bag and tubing off the floor during multiple observations on 5/11/16. The findings include: 1. Resident #124 was admitted to the facility on 4/26/16 with diagnoses that included but were not limited to, end-stage kidney disease, high blood pressure, diabetes and chronic c-dif (clostridium difficile). The most recent MDS, an admission assessment, with an ARD of 5/3/16 coded the resident as 13 out of 15 on the BIMS indicating	F 441	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 441	Continued From page 121 the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as being frequently incontinent of stool. In section "I – Active diagnoses" the resident was coded as having "ENTEROCOLITIS** DUE TO CLOSTRIDIUM DIFFICILE." An observation was made of Resident #124 on 5/11/16 at 1:42 p.m. Resident #124 was sitting up in a wheelchair next to her bed. The resident's roommate was in a wheelchair at the foot of her bed. An observation was made of Resident #124 on 5/12/16 at 9:07 a.m. Resident #124 was lying in bed on her left side, she was wearing a brief that was not visibly soiled. The resident's roommate was in a wheelchair at the foot of the bed. A staff member was coming out of the room. Review of Resident #124's care plan dated 4/26/16 documented in part, "6. Infection Alert. Type: Chronic CDiff. Monitor for S/S (signs and symptoms) infection -- loose stools. Meds as ordered. Isolation: D/C (discontinued)." Review of the physician's orders dated, 4/28/16 documented, "D/C (discontinue) contact precautions." Review of Resident #124's nurses' notes dated 5/5/16 documented in part, "Incontinent of bowel and bladder. N.O. (new order) from MD anusol supp (suppository) 1 via rectum daily X (times) 10 days, tucks to rectal area after each loose stool PRN (as needed) for hemorrhoids." Review of the physician's orders on 5/5/16	F 441		

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F 441	Continued From page 122 documented, "Anusol Supp 1 via rectum daily X 10 days Tucks to rectal area after each loose stool." Review of Resident #124's nurses' notes dated 5/6/16 and timed "11-7 (11:00 p.m. to 7:00 a.m.)Resident remain (sic) skilled care, ABT (antibiotic)/c-diff continues...X1 loose stool." The documentation did not evidence that the physician had been notified. Review of the nurses' notes dated 5/6/16 and timed "7-3 (7:00 a.m. to 3:00 p.m.)" documented, "Resident had loose stools X1 this shift. No blood noted when rendering incontinence care." The documentation did not evidence that the physician had been notified of the loose stool. Review of Resident #124's MAR dated 5/5/15 documented, "Anusol Supp 1 via rectum QHS X 10 day (sic)." It was documented that the resident received the suppository on 5/6/16, 5/7/16, 5/8/16, 5/10/16 and 5/11/16. Further review documented, "Tucks to rectal area after each loose stool as needed PRN." There was no documentation that the resident had been treated with the Tucks. Review of the physician's orders on 5/6/16 documented, "C diff stool X 1." Review of the unit's 24 hour report documented in part: 5/6/16, "(Name of resident #124). ABT (antibiotic)/C-diff. ?Contact Precautions? 11-7 No reactions X1 loose stool. Vanc (Vancomycin) in route this am from pharmacy. 7-3. ABT; no adverse reactions. Loose stool X 1. 3-11 (3:00 p.m. to 11:00 p.m.) stool samp (sample). Call lab for pickup."	F 441		

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F 441	Continued From page 123 5/8/16, "(Name of resident #124). 11-7 Loose Stools." 5/9/16, "(Name of resident #124). 11-7. Resident is not on contact precautions, 1 reported loose stool....she has loose stools daily. Please F/U (follow up) in am (c with a line over it meaning with) order for contact, she ambulates with loose foul stool." 5/10/16, "(Name of resident #124)., 11-7. D/T (due to) No F/U on stool sample called Lab (laboratory) No record received. Loose stools daily (with) foul odor. "?contact precaution?" Resides in semi-private room with loose/foul stool. *Tx (treated) for C-diff. F/U (with) MD (medical doctor) RE: contact precaution order." 5/11/16, "(Name of resident #124). F/U (with) MD RE: CONTACT PRECAUTION." Review of the resident's record did not evidence documentation that the physician had been notified about the loose stools or to follow up on the need for contact precautions. Review of Resident #124's nurses' notes dated 5/10/16 and timed 7:00 a.m. to 3:00 p.m. documented in part, "Incontinent of bowel and bladder." 3:00 p.m. to 11:00 p.m. nurse's note documented in part, "Rsd (resident) has diagnosis of c-diff (a 0 with a line through it meaning no) contact precautions present/ in semi private room (with) roommate." The documentation did not evidence that the physician had been notified. An interview was conducted on 5/12/16 with ASM #6, the medical director. When asked what if anything would he do if a resident with a diagnosis of C-diff continued to have loose stools, ASM #6 stated, "If they're still having loose stools they should call the doctor. I would keep the	F 441		

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F 441	Continued From page 124 resident in isolation if still having loose stools because the C-diff is still positive." An interview was conducted with CNA (certified nursing assistance) #11, the aide caring for Resident #124. When asked what process staff followed if a resident had loose stools CNA #11 stated, "Notify the nurse." When asked if the resident had had any loose stools that day, CNA #11 stated, "She hasn't had any." When asked what infection control process staff used when a resident had C-diff, CNA #11 stated, "You have to wash your hands with soap and water." When asked how she sanitized her hands for Resident #124 she stated that she used soap and water. An interview was conducted with ASM #3, the assistant director of nursing. When asked about the 24 hour report for Resident #124, ASM #3 stated, "If I speak honestly, I don't recall being part of that discussion." When asked if she would be concerned about the resident continuing to have loose stools, ASM #2 stated, "Absolutely, we would call the doctor and get a (stool) specimen." An interview was conducted on 5/12/16 at 8:40 a.m. with LPN #9, the unit manager. When the 24 hour report was reviewed, LPN #9 stated, "I might not have seen this yesterday morning, I was pulled to the cart (medication cart)." When asked what process she would follow knowing the information on the 24 hour report, LPN #9 stated, "I would look at the whole situation, the loose stools, the culture, did anyone contact the M.D. (medical doctor)." When asked what process staff followed for a resident with C-diff, LPN #9 stated, "Most time when patient has C-diff they're placed in a private room, they have their own bin (for trash), staff gown and glove up." When asked	F 441		

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F 441	Continued From page 125 what the reason for the resident to have their own room, LPN #9 stated, "It's (C-diff) highly contagious." On 5/12/16 at 3:20 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. 2. Resident #126 was admitted to the facility on 9/29/15 and was readmitted on 3/20/16 with diagnoses that included but were not limited to: seizures, muscle weakness, heart failure and depression. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/13/16 coded the resident as 13 out of 15 on the BIMS (brief interview of mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring set up assistance for activities of daily living. An observation was made on 5/10/16 at 12:30	F 441		

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F 441	Continued From page 126 p.m. of CNA (certified nursing assistant) #14. The CNA come around the curtain of the resident next to the window holding plastic bag in her gloved hands. CNA #14 stood at the sink, removed her gloves and, without washing her hands, put on another pair of gloves, tied up the plastic bag and took it out of the room. CNA #14 returned to the room, removed her gloves and picked up the lunch tray for Resident #126 and put it on her over bed table. CNA #14 did not wash her hands before giving the resident her lunch tray. An interview was conducted on 5/11/16 at 11:40 a.m. with LPN (licensed practical nurse) #1. When asked what infection control process staff followed when providing care to a resident, LPN #1 stated, "Wash hands between patients and after contact with patients." An interview was conducted on 5/11/16 at 1:48 p.m. with CNA #12. When asked the process staff followed when providing resident care, CNA #12 stated, "You put on gloves when helping (the resident), take gloves off and wash your hands. Of course you don't go from resident to resident with the same gloves." When asked if staff should wash their hands after touching the residents, CNA #12 stated, "Oh, yes. I always wash my hands." An interview was conducted on 5/11/16 at 2:12 p.m. with CNA #13. The observation was of 5/10/16 at 12:30 p.m. was described to CNA #13. CNA #13 stated, "First and foremost she should have taken her gloves off before going into the hallway and she should have washed her hands before handling the tray for the other resident." An interview was conducted on 5/11/16 at 3:42 p.m. with ASM (administrative staff member) #2,	F 441		

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F 441	Continued From page 127 the director of nursing. ASM #1, the administrator was also present. When asked what infection control process staff followed when providing care to a resident, ASM #2 stated, "Staff should wear gloves anytime touch body fluids, wear gloves during incontinent care. The need to wash their hands before and after care between resident." The observation of 5/11/16 at 12:30 p.m. was described to ASM #2. ASM #2 stated, "She should have washed her hands as soon as she emptied that trash and took her gloves off. She should have washed her hands." No further information was provided prior to exit. In Fundamentals of Nursing, Lippincott Williams and Wilkins, page 140-143, concerning hand washing and the use of hand sanitizer: "The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Hand hygiene is the single most important procedure in preventing infection....typically hands are washed with soap before coming on duty; before and after direct or indirect patient contact;...before preparing or administering medications...always wash your hands with soap after removing gloves...when using hand sanitizer, apply a small amount of the alcohol-based hand rub to all surfaces of the hands. Rub hands together until the entire product has dried (usually about 30 seconds)." A review of a pages 1518 - 1520 from Fundamentals of Nursing, Potter and Perry, 6th edition, the facility's standard of practice, and provided to the surveyor as part of the facility's wound care policy, revealed, in part, the following as the procedure to be followed once a clean dressing has been applied to a wound: "Remove	F 441		

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 441	Continued From page 128	F 441		

gloves and dispose of soiled supplies. Perform hand hygiene."

3. Resident #127 was admitted to the facility on 11/4/14 with diagnoses that included but were not limited to: high blood pressure, elevated cholesterol and arthritis.

The most recent MDS, an annual assessment, with an ARD of 3/8/16 coded the resident as having 15 out of 15 on the BIMS, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance of two staff for all activities of daily living except for eating which the resident could perform after her tray was set up. The resident was coded as always being incontinent of urine and stool.

An observation was made on 5/10/16 at 12:30 p.m. of CNA (certified nursing assistant) #14. The CNA come around the curtain of Resident #127. There were two bed pads on the foot of the bed. CNA #14 was holding plastic bag in her gloved hands. CNA #14 stood at the sink, removed her gloves and, without washing her hands, put on another pair of gloves, tied up the plastic bag and took it out of the room. CNA #14 returned to the room, removed her gloves and picked up the lunch tray for Resident #126 and put it on her over bed table. CNA #14 did not wash her hands before giving the resident her lunch tray.

CNA #14 was not available for interview on 5/11/16.

An interview was conducted on 5/11/16 at 11:40 a.m. with LPN (licensed practical nurse) #1. When asked what infection control process staff

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F 441	Continued From page 129 followed when providing care to a resident, LPN #1 stated, "Wash hands between patients and after contact with patients." An interview was conducted on 5/11/16 at 1:48 p.m. with CNA #12. When asked the process staff followed when providing resident care, CNA #12 stated, "You put on gloves when helping (the resident), take gloves off and wash your hands. Of course you don't go from resident to resident with the same gloves." When asked if staff should wash their hands after touching the residents, CNA #12 stated, "Oh, yes. I always wash my hands." An interview was conducted on 5/11/16 at 2:12 p.m. with CNA #13. The observation was of 5/10/16 at 12:30 p.m. was described to CNA #13. CNA #13 stated, "First and foremost she should have taken her gloves off before going into the hallway and she should have washed her hands before handling the tray for the other resident." An interview was conducted on 5/11/16 at 3:42 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #1, the administrator was also present. When asked what infection control process staff followed when providing care to a resident, ASM #2 stated, "Staff should wear gloves anytime touch body fluids, wear gloves during incontinent care. The need to wash their hands before and after care between resident." The observation of 5/11/16 at 12:30 p.m. was described to ASM #2. ASM #2 stated, "She should have washed her hands as soon as she emptied that trash and took her gloves off. She should have washed her hands." No further information was provided prior to exit.	F 441		

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F 441	Continued From page 130 4. For Resident #129, facility staff failed to dispose of a wheelchair cushion saturated in urine in a sanitary manner. Resident #129 was admitted to the facility on 9/1/2015 with diagnoses that included but were not limited to high blood pressure, GERD (gastroesophageal reflux disease), high cholesterol, thyroid disorder, and Non-Alzheimer's dementia. Resident #129's most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 2/8/16. Resident #129 was coded as being severely impaired in cognition scoring 3 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #129 was coded as requiring extensive assistance from staff with dressing, personal hygiene, and bathing; independent with ambulation and eating; and supervision with toileting. Resident #129 was coded as being incontinent of bowel and bladder. On 5/12/16 at 8:20 a.m., observation of the Hanover (secured unit) was conducted. A strong urine odor was coming from Resident #129's room. The resident was not in the room and the bed was stripped. At 8:30 a.m., CNA (certified nursing assistant) #1 approached this surveyor. She stated, "The resident had an accident and I cleaned it up but I am waiting for housekeeping to come in and sanitize the bed. The resident was in the dining room earlier but she likes to walk into her room and pee on the bed or the floor." At 9:30 a.m., house cleaning was observed sanitizing Resident #129's bed and floor. The urine spell dissipated after the room was sanitized. On 5/12/16 at 11:30 p.m., there was a strong urine odor coming from Resident #129's room.	F 441		

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F 441	Continued From page 131 On 5/12/16 at 1:00 p.m. the urine odor was still present. Review of Resident #129's care plan revised 2/25/16 documented the following under care area Behavior/Mood, "Socially inappropriate behavior (specify) urinates on floor..." Review of Resident #129's care plan revised 2/25/16 documented the following under care area Elimination GU (urinary), "Focus: The resident has altered bladder elimination...Approaches and Interventions: ...Check for incontinence. Wash, rinse and dry soiled areas..." On 5/12/16 at 1: 00 p.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked how urine is cleaned after an incontinent episode she stated, "The CNA's pick up the urine or stool but then we call housekeeping to sanitize the room." When asked if this was done each time a resident has an incontinent episode she stated, "Yes." When asked if housekeeping responds right away she stated, "Yes, they are very good about cleaning the room right away." When asked what she could tell me about Resident #129 she stated, "She has a lot of incontinent episodes. She will pee on the floor, on her bed, take her soiled clothes off and hang them over the railing in the hallway. CNA #1 stated, "Her room still smells now. She actually just had an accident in her wheelchair when she was on her way back from activities. The activities assistant brought her back and her wheelchair cushion was all wet." When asked what time she came back from activities she stated, "Around lunch time. I cleaned her up but I didn't have time to get a large bag for her cushion so it is in the bathroom	F 441		

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F 441	Continued From page 132 right now. When asked to see the wheelchair cushion, CNA #1 opened the bathroom door. The wheelchair cushion was observed on the floor in the corner of the bathroom soiled from urine. When asked why she did not have time to clean the cushion right away she stated, "It was during meal trays and I have to prioritize my tasks." When asked why leaving the soiled cushion in the corner of the bathroom was a concern she stated, "It is an infection control issue." When asked how she usually cleans wheelchair cushions she stated, "We bag them and give to housekeeping. I haven't had a chance to tell housekeeping yet." On 5/12/16 at 1:10 p.m., an interview was conducted with OSM (Other Staff Member) #6, housekeeping. She stated that she has never been asked to clean a wheelchair cushion before. On 5/12/16 at 1: 15 p.m., an interview was conducted with CNA #17. When asked the process if a resident soils a wheelchair cushion she stated, "We usually will just throw them away and get a new cushion from therapy. Sometimes the cushions have a covering that will be carried to laundry." She stated the covering is carried in a plastic bag. On 5/12/16 at 1:18 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #6. When asked the process if a resident soils a wheelchair cushion she stated, "Contact maintenance and they will pressure wash the cushion or we throw away the cushion and ask therapy for a new one." She stated the cushion should always be bagged and never tossed on the floor. She stated soiled linens or cushions should never be placed on the floor because of cross contamination.	F 441		

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F 441	Continued From page 133 On 5/12/16 at 2:24 p.m., an interview was conducted with OSM (Other Staff Member) #5 the maintenance director. He stated that the CNA's will wipe the wheelchair cushion after a resident has an incontinent episode and then will bag the cushion and give to maintenance to pressure wash. Facility policy titled, "Exposure Control Plan: Linen Handling" did not address the handling of soiled wheelchair cushions. On 5/12/16 at 2:54 p.m., ASM (Administrative Staff Member) #2, the DON (Director of Nursing) was made aware of the above findings. No further information was presented prior to exit. 5. Facility staff failed to dispose three boxes of gloves that were contaminated by Resident #128. Resident #128 was admitted to the facility on 2/9/16 and readmitted on 2/17/16 with diagnoses that included but were not limited to type two diabetes mellitus, high blood pressure, dementia with behavioral disturbance, and anxiety disorder. Resident #128's most recent MDS (Minimum Data Set) was an admission assessment with an ARD (assessment reference date) of 2/24/16. Resident #128 was coded as being severely cognitively impaired scoring 3 out of 15 on the BIMS (Brief Interview of Mental Status) exam. Resident #128 was coded as requiring extensive assistance from staff with dressing, toileting, personal hygiene, and bathing; and supervision with ambulation and eating. On 5/12/16 at 9:15 a.m., Resident #128 was observed walking down the hallway with three (open) boxes of gloves held to her chest. The	F 441		

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open part of all three boxes of gloves was against Resident #128's shirt. At 9:16 a.m., LPN (Licensed Practical Nurse) #5 took the boxes of gloves from Resident #128 and walked into room 313 with the gloves. At 9:17 a.m., LPN #5 walked out of room 313 without the gloves. Room 313 was not Resident #128's room. At 9:17 a.m., the three boxes of gloves were observed to be on top of a television that belonged to another Resident in room 313.

On 5/12/16 at 10:41 a.m., an interview was conducted with LPN #5. When asked where she had placed the three boxes of gloves Resident #128 had been carrying she stated, "In room 313, I hid them." LPN #5 showed this surveyor the three boxes of gloves. She stated, "I am not sure where she got these gloves from." LPN #5 was asked if room 313 was Resident #128's room, she stated, "No, this is not her room." LPN #5 stated that she was not sure how Resident #128 was carrying the gloves. When told LPN #5 the above observation she stated, "I never thought about that, whether they were considered contaminated." LPN #5 took the boxes of gloves out of the room and disposed of them in the trash.

On 5/12/16 at 11:00 a.m., an interview was conducted with CNA #1. When asked the process if she observed a resident holding a box of gloves (open side to the chest) she stated, "Throw them away. You don't know what the gloves have touched."

Facility policy titled, "Disposable Non-Sterile Gloves" did not address the above concern.

On 5/12/16 at 2:54 p.m., ASM (Administrative Staff Member) #2, the DON (Director of Nursing)

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F 441	Continued From page 135 was made aware of the above findings. No further information was presented prior to exit. 6. Resident #107 was admitted to the facility on 11/1/10 and most recently readmitted on 4/15/16 with diagnoses including, but not limited to: end stage renal disease requiring dialysis, intellectual disability, diabetes, glaucoma, testicular cancer and blindness. On the most recent MDS (minimum data set), a 14-day Medicare assessment with ARD (assessment reference date) 4/19/16, Resident #107 was coded as being severely cognitively impaired for making daily decisions, having scored four out of 15 on the BIMS (Brief Interview for Mental Status). He was coded as having an indwelling catheter. On 5/10/16 at 12:30 p.m. and 3:25 p.m., and on 5/12/16 at 7:55 a.m., Resident #107 was observed lying in his bed with the blanket pulled over his head. At each observation, the catheter drainage bag and part of the catheter tubing were touching the floor. A review of the physician's orders revealed, in part, the following order, written 5/1/16: "Foley cath (catheter) 16 Fr (16 French - denotes size of catheter) for urinary retention. Foley catheter care q shift (each shift)." A review of the comprehensive care plan for Resident #107 dated 2/2/16 and updated on 5/9/16 revealed, in part, the following: "The resident has altered bladder elimination...cath (catheter care) as ordered and prn (as needed)."	F 441		

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F 441	Continued From page 136 On 5/12/16 at 8:55 a.m., LPN (licensed practical nurse) #7 was interviewed regarding Resident #7's catheter drainage bag and tubing touching the floor. She stated: "It needs to be picked up. The bag and the bagging need to be changed. It should not be dragging the floor." When asked why these items should not be in contact with the floor, she stated: "It is infection control. These residents are already prone to infection. The bag and tubing should not be in contact with the dirty floor." On 5/12/16 at 9:00 a.m., CNA (certified nursing assistant) #3 was asked what she would do if she entered a room and observed a resident's catheter drainage bag and catheter tubing in contact with the floor. She stated: "It can't be on the floor. I would go get the nurse because it can't be on the floor. It's an infection control thing." On 5/12/16 at 3:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the corporate consultant, and ASM #5, the corporate MDS consultant, were informed of these concerns. A review of the facility policy entitled "Catheterization, Male and Female Urinary" revealed, in part, the following: "Tubing must be off of the floor at all times." No further information was provided prior to exit. *"A soft, plastic or rubber tube that is inserted into the bladder to drain the urine." This information is taken from the website http://www.nlm.nih.gov/medlineplus/ency/article/003981.htm	F 441		

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F 441	Continued From page 137 According to Fundamentals of Nursing, Lippincott Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage system: 2. Maintain an unobstructed urine flow. b. Urine should not be allowed to collect in tubing because free flow of urine must be maintained to prevent urinary tract infection. Improper drainage occurs when the tubing is kinked or twisted, allowing pools of urine to collect in the tubing. c. Keep the bag off the floor to prevent bacterial contamination." COMPLAINT DEFICIENCY	F 441		
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to	{F 514}	1.Resident #116 no longer resides in the facility. Facility staff updated the plan of care for resident #130 to include history of making threats to others. Unable to conclude why there were circled blood sugar check for resident #115. Resident #110 has an updated safety care plan. 2. Residents that reside in the facility have the potential to be affected. Resident #130 has not made any threats to other residents. Medication Administration Records (MARS) and of current diabetic residents will be audited to ensure physician ordered blood glucose testing has been completed and those that have not been completed have appropriate documentation.	6/22/16

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(F 514)	Continued From page 138 maintain a complete and accurate clinical record for four of 30 residents in the survey sample, Residents #116, #130, #115 and #110. 1. The facility staff failed to document their interventions to immediately separate Resident #116 from his roommate (Resident #130) following a threat made by Resident #130 toward Resident #116 on 5/9/16. 2. The facility staff failed to document Resident #130's threat to his roommate (Resident #116) on 5/9/16. 3. Facility staff failed to document why a blood sugar on 5/4/16 at 9:00 p.m. was not done; the nurse circled her initials but did not document on the back of the MAR the reason why the blood sugar was not done. 4. Facility staff failed to maintain an accurate care plan for Resident #110 under care area "Safety." The findings include: 1. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline. Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease,	(F 514)	3. Licensed nurses will be educated on accurate documentation of medical records to include refusal of blood glucose monitoring by DCS/designee. In-servicing will be provided to licensed nursing staff to address updating plan of care for changes in condition and behavioral outburst. This in-service will also include the notification of MD/RP. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure that the any behavioral episodes have been added to the plan of care, MD/RP have been notified and immediate interventions in place. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure blood glucose testing has been performed as ordered by MD and any refusal have been documented along with MD/RP notification.	

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{F 514}	Continued From page 139 epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. On the following dates and times during the survey, Residents #116 and #130 were observed in the same room: 5/10/16 at 3:15 p.m.; 5/11/16 at 7:40 a.m. and 5:15 p.m. On 5/12/16 at 8:10 a.m., Resident #116 was observed to have been moved to a different room. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of the Admission Care Plan for Resident #116 dated 5/2/16 listed the following interventions under the heading "Falls/Safety/Elopement Risks: " Orthostatic hypotension precautions (to prevent low blood	{F 514}	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 514}	Continued From page 140 pressure when quickly sitting or standing up), ambulation devices as necessary, assess cognitive status as ability to ask for assistance, assess resident footwear for fit and non-skid soles, encourage activity, safety checks, orthostatic BP (blood pressure) checks. Further review of the clinical record revealed no further evidence that the facility staff addressed Resident #130's threats to Resident #116, or assessed Resident #116 for safety needs. The record revealed no evidence that Resident #116 was protected from further threats or harm from Resident #130. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #3, the assistant director of nursing, was interviewed regarding the above referenced nurse's note. She was asked to provide the surveyor with an incident report and investigation regarding the threat Resident #130 made to Resident #116. She stated that she did not have any further documentation regarding this incident. She stated that she was aware that the nurse working the floor when the incident occurred separated the residents immediately, and kept Resident #116 at the nurse's station until Resident #130 had gone to sleep. She stated that when Resident #130 went to sleep, the facility staff assisted Resident #116 back into his bed (in the same room as Resident #130). On 5/11/16 at 6:10 p.m., LPN #11 was interviewed about the above referenced incident. She stated that she was initially focused on Resident #116's fall and on assessing him for any injuries. She stated that her assessment revealed no apparent injuries for Resident #116. She stated that Resident #116 was being "very loud and unsteady" in his room, and that Resident	{F 514}		

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	495362	A. BUILDING _____ B. WING _____	R-C 05/12/2016

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{F 514}	Continued From page 141 #130 said: "If you can't make him sit his [expletive] down, I will make him sit it down." She stated that she put Resident #116 in a wheelchair and took him to sit at the nurse's station for the duration of the shift. She stated that Resident #130 went to sleep, and she assisted Resident #116 back to his bed at that time. She stated that she told the supervisor about this, and that the supervisor told her to make sure the residents were separated and monitored to make sure there were no other incidents. When asked if she recorded any of this information in the clinical record, she stated: "No, I didn't. I know I should have." On 5/12/16 at 8:25, LPN #9, the unit manager, was interviewed regarding what she would do if she was notified of a resident threatening another resident. She stated that the residents should be separated for safety. She stated that she would alert the director of nursing. When asked if she would document any of her actions, she stated that she would write a nurse's note about what happened and about any action she took. She stated that the doctor and the RP should also be notified. When asked if she was told about an incident between Resident #116 and #130, she stated: "I didn't hear exactly what was said. I was just told they were arguing. I told the nurse that we need to get them moved." When asked if this information was shared in the morning meeting at any point, she stated: "I brought the chart to the morning meeting on [the day following the incident] (5/10/16)." She stated: "There absolutely should have been an investigation." She stated she could not recall exactly what she had shared or what had been discussed at the morning meeting on 5/10/16. On 5/12/16 at 8:40 a.m., LPN #10, the evening	{F 514}		

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NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 514}	Continued From page 142 supervisor on 5/9/16, was interviewed regarding the process to be followed when a resident was threatened by a roommate. She stated: "If it was an actual threat, I would separate them and notify my boss. I would get witness statements from anyone who saw or heard anything, whether it was staff or residents." When asked how she determined that a threat was an "actual" one, she stated: "An actual threat would be if a patient said that they would hurt someone or had actually hurt someone." When asked about the above referenced incident between Resident #116 and Resident #130, she stated: "It was not brought to me as a threat." She said that another staff member had told her that Resident #130 had made a statement and that we needed to do something about Resident #116 falling all over the place." She stated that her concern was much more about the resident's unsteadiness and risk for falls. She stated that a CNA (certified nursing assistant) sat with Resident #116 the remainder of the night shift to make sure he was safe. She stated: "We kept him safe all night. We monitored him all night." She stated that if she had been told exactly what Resident #130 had said, she would have moved Resident #116 to a different room. When asked if she passed on any information about this incident to the next shift, she stated: "I would have passed it on myself. It was not on the 24-hour report. I should have put it on there." When asked if the incident should have been investigated as an incident of abuse, she stated: "Yes. Yes it should have. If I had known what really happened, I would have." On 5/11/16 at 5:50 p.m., ASM #1, the executive director, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the regional consultant, were informed of these concerns.	{F 514}		

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{F 514}	Continued From page 143 A review of the facility policy entitled "Nurse Progress Notes" revealed, in part, the following: "A resident's progress shall be documented in the record as required. The nurse shall utilize the Progress Note to document resident progress. The note will be written legibly in black ink and shall include the following but not limited to: Date, Time (specific, not block time), Resident specific information, Signature with credentials." No further information was provided prior to exit. According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: " Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team." 2. Resident #116 was admitted to the facility on 5/3/16 with diagnoses including, but not limited to: schizophrenia, dementia, high blood pressure, and depression. On Resident #116's admission nursing assessment dated 5/3/16, he was coded as having both short term and long term memory problems. He was coded as having a history of depression, but was coded as not having any behaviors. He was coded as having an alteration in safety awareness due to cognitive decline.	{F 514}		

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{F 514}	Continued From page 144 Resident #130 was admitted to the facility on 10/10/13 and most recently readmitted on 11/21/14 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, epilepsy, heart failure, agitation and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with (ARD) assessment reference date 3/10/16, Resident #130 was coded as having moderate cognitive impairment for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). He was coded as having exhibited no behaviors during the look back period. A review of the clinical record for Resident #116 revealed the following nurse's note, dated 5/9/16 at 7:30 p.m. and written by LPN (licensed practical nurse) #11: "Charge nurse on middle hall giving out medication. Called to Front Hall [wing number] by other residents. Resident noted on floor in hallway. Denies pain or discomfort. [Names of other residents] state they didn't see him fall but they heard him hit the floor. Resident extremely confused wandering and fumbling around in the room to the point the roommate is upset and threating (sic). MD (physician) called and made aware of fall. Request b/p (blood pressure) to be rechecked. BP 132/60...Call placed to MD. Awaiting return call @ (at) this time." A review of Resident #130's clinical record revealed no nurses' notes after 5/2/16. The record contained no evidence of an altercation between Resident #130 and Resident #116 on 5/9/16. On 5/12/16 at 1:10 p.m., LPN #8 was interviewed regarding what should be documented if a	{F 514}		

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{F 514}	Continued From page 145 resident makes a threat against another resident. She stated: "It should go in both resident charts. I would write a note in each of the charts. I would say what happened and who I called." On 5/12/16 at 1:15 p.m., LPN #9, a unit manager, was interviewed regarding what should be documented if a resident makes a threat against another resident. She stated that the events should be documented in both residents' progress notes. She stated that after the residents are separated and the physician and RP are notified, everything that happened with both residents should be documented. On 5/12/16 at 3:10 p.m., ASM #1, ASM #2, ASM #3, ASM #4 and ASM #5, the corporate MDS consultant, were informed of these concerns. No further information was provided prior to exit. 3. Resident #115 was admitted to the facility on 4/26/11 with diagnoses that included, but were not limited to: cancer, cirrhosis, hepatitis C, diabetes, hypertension, and gastroesophageal reflux disease. The most recent MDS (minimum data set) assessment, was an annual assessment with an ARD (assessment reference date) of 2/8/16. Resident # 115 was coded as scoring 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was cognitively intact Review of the clinical record revealed a physician order originally dated 2/1/16 and most recently signed by the physician on 4/1/16 documented: "CHECK BLOOD SUGAR AT BEDTIME CALL MD < 60 (less than 60) OR > 450 (greater than	{F 514}		

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{F 514)	Continued From page 146 450)" Review of the MAR (medication administration record) for May 2016 revealed no documentation as to why Resident # 115's blood sugar was not checked on 5/4/16 at 9:00 p.m. During an interview on 5/11/16 at 3:45 p.m. with LPN (licensed practical nurse) # 2 the circled initials for 5/4/16 at 9:00 p.m. on Resident # 115's MAR was reviewed. LPN # 2 stated, "If it is circled there should be remarks on the back (of the MAR) as to why it was not done." The back of the MAR was reviewed with LPN # 2 and LPN # 2 confirmed that there was no reason documented. During an interview on 5/12/16 at 8:45 a.m. with RN (registered nurse) # 3, a unit manager, the circled initials on Resident # 115's MAR for 5/4/16 at 9:00 p.m. were reviewed. RN # 3 stated that the nurse should have put something on the back and RN # 3 gave examples of reasons that could have been documented. RN # 3 confirmed that there was no documentation on the back of the MAR for the circled initials. During an interview on 5/12/16 at 9:50 a.m. with ASM (administrative staff member) # 1, the administrator, this concern was shared and the facility policies related to this issue were requested. During an interview on 5/12/16 at 10:20 a.m. with ASM # 3, the assistant director of nurses, ASM # 3 reported that she (ASM # 3) could find no documentation as to why that Resident # 115's blood sugars was not done on 5/4/16 at 9:00 p.m. Review of the facility policy: Clinical/Medical	(F 514}		

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{F 514}	Continued From page 147 Records documented the following under "Policy...Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care ...The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care..." No further information was provided prior to exit. According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team." Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is	{F 514}		

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{F 514}	Continued From page 148 accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management." 4. Resident #110 was admitted to the facility on 2/5/2014 and readmitted on 4/10/16 with diagnoses that included but were not limited to Schizoaffective disorder, dementia with behavioral disturbance and type two diabetes mellitus. Resident #110's most recent MDS (Minimum Data Set) was significant change assessment with an ARD (Assessment Reference Date) of 5/2/16. Resident #110 was coded as being severely impaired in cognitive status scoring a three on the staff interview for mental status exam. Resident #110 was coded as requiring limited assistance from staff with ambulation; extensive assistance from staff with transfers, dressing, eating, toileting, and personal hygiene; and dependent on staff with bathing. Resident #110 was coded as receiving hospice services. Review of Resident #110's clinical record revealed an SBAR (Situation, Background, Assessment and Recommendation) assessment dated 4/30/16 that documented the following: "Resident fell and hit head." A nurses noted dated 5/2/16 documented the following: "Resident s/p (status post) incident, 0 (zero) new injury vs vital signs 108/54, p (pulse) 73, R (respirations) 18, T(temp) 97.6." Review of the incident reported dated 4/30/16	{F 514}		

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{F 514)	Continued From page 149 documented in part, the following: "...3. Implemented interventions, including adequate supervision, and/or assistive devices to reduce the risk of an accident that were consistent with the resident's needs, goals, plan of care and current standards of practice: a. Interventions implemented due to hazards and risks: i. gripper socks, ii. increase supervision, iii. increase encouragement with activities...Care plan revisions: i. encourage increase with activities participation ii. Hospice suggest/poss. (possibility) of soft helmet." Review of Resident #110's care plan dated 3/3/16 documented the following interventions under problem area "Safety" on 4/30/16: (1) 4/30/16 The resident needs out of room activities that minimize the potential for falls while providing diversion and distraction, encourage participation, 2) 4/30/16 Helmet via hospice." On 5/10/16 and 5/11/16, Resident #110 was observed multiple times on the secured unit not wearing a helmet. Review of the hospice notes dated 4/30/16 documented in part the following: "...Discussed possible fall interventions with nurse to include possibility of a soft helmet, nurse suggest to follow up on Monday with regular staff to see if its allowed at facility..." No further follow up hospice or nurse's note could be found regarding the use of a soft helmet. Review of Resident #110's most recently signed POS (Physician Order Sheet) dated 5/1/16 through 5/31/16 revealed that Resident #110 did not have an order for a soft helmet.	{F 514)		

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{F 514}	Continued From page 150 On 5/11/16 at 3:40 p.m., an interview was conducted with Resident #110's hospice nurse from an outside agency. When asked if Resident #110 was supposed to be wearing a helmet he stated, "No. What had happened was the day that she fell; our on call nurse went over and assessed her. The nurse called me to see if a soft helmet was necessary. There is no way she would keep a soft helmet on her head. We did not suggest a soft helmet for her." On 5/11/16 at 3:50 p.m., an interview was conducted with RN (Registered Nurse) #1, the new unit manager. She stated that she was not sure why a soft helmet was placed on Resident #110's care plan. She stated, "I was not the unit manager during that time and the old unit manager does not work here anymore." She stated that the unit managers were responsible for updating the care plans. She stated, "The facility is trying to get the floor nurses to update the care plan as well but back during this time it was just the unit managers updating the care plan or MDS." She stated that this intervention should not have been put on the care plan. On 5/11/16 at approximately 4:00 p.m., an interview was conducted with LPN #19, the MDS nurse. When asked who was responsible for updating the care plan she stated, "Any nurse can update the care plan. Nurses should be updating the care plan if they are taking off orders or working during a status change." She stated that she as not familiar with Resident #110's intervention for a soft helmet. She stated, "That could have been anybody." On 5/11/6 at approximately 4:30 p.m. an interview was conducted with ASM (administrative staff member) #1, the administrator. He stated he had	{F 514}		

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{F 514}	Continued From page 151 just adopted Resident #110 as his "adopt a resident" two weeks ago. He stated, "Just knowing what I know about her in the last two weeks, there is no way she would leave a helmet on. A helmet was never planned to be put on her." On 5/11/16 at approximately 4:30 p.m., ASM #1, the administrator was made aware of the above concerns. Facility policy titled, "Clinical/Medical Records" documents in part the following: "Clinical records are maintained in accordance with professional practice standards to provide complete and accurate information in each resident for continuity of care...The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care." The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner."	{F 514}		

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{F 514}	Continued From page 152 No further information was presented prior to exit.	{F 514}		